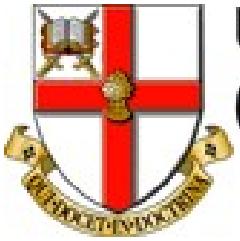

University of Chester

Department of Clinical Sciences and Nutrition

MSc Public Health Nutrition

Project Title: Evaluating Practice within a Community Health Promotion Intervention – What is the Evidence for Successful Techniques, Empowerment and Community-Centred Approaches?

Name: Judith Fynn

Student Number: 1429818

Assessment Number: J21398

Date Submitted: 31 October 2016

Word Count: 8818

Declaration of Own Work

I hereby confirm that the work submitted for this assessment is my own work and that I correctly acknowledged the work of others. I declare that this assignment does comply with the word count specified.

Signed: Judith Fynn, Assessment Number: J21398

Acknowledgements

I would like to thank all the team at the CIC for allowing me to base this study on the community health intervention they provide. Especially Séona and Georgie for their time and support, without which the study would not have been possible; and the rest of the team for welcoming me and their willingness to share conversations and lunches. Also, thank you to the intervention participants for agreeing to take part in the study.

Thank you to Dr. Rehana Jawadwala, my supervisor, for her advice and support, and pushing me to keep focused. Also, thank you to Professor Stephen Fallows and Claire Glazzard for advice and encouragement at various stages in the research process.

Finally, I also thank my boys, big and small, for their patience and encouragement, and allowing me time to travel and study - my husband Paul, my chief sponsor, and my four sons, my chief moral boosters.

Portfolio Contents

List of Tables and Figures

List of Abbreviations

CIC	Community Interest Company
DoH	Department of Health
GENIE	Guide for Effective Nutrition Interventions and Education
ME	Measuring Empowerment
NICE	National Institute of Health and Care Excellence
NHS	National Health Service
NOO	National Obesity Observatory
PHE	Public Health England
SEF	Standard Evaluation Framework
WHO	World Health Organisation

Department of Clinical Sciences and Nutrition

MSc Public Health Nutrition

Literature Review

Name: Judith Fynn

Assessment Number: J21398

Date Submitted: 31 October 2016

Word Count: 4244 words

Contents

Table of Tables

Table of Figures

Abstract

Community-centred approaches are central to health promotion policy, strategy and practice to address current Public Health concerns. Community interventions are complex and context specific; their design, delivery and evaluation are influenced by a complex set of factors and priorities. Participation, empowerment, and capacity building are viewed as fundamental constructs within community-centred approaches, yet how these are conceptualised, operationalised and evaluated remains contested. Evaluation and reporting is important to expand the evidence base, to improve understanding, and to inform strategy and practice in health promotion. Evaluation is often constrained by organisational, resourcing and translational factors that can limit evaluation as a tool to identifying successful techniques, gaps and good practice. Greater acceptance of qualitative and mixed methods within Public Health evaluation offers an opportunity to combine systematic and flexible methods to evaluate what happens in practice within community-centred health promotion interventions and expand the evidence base, that may help to close the gap between theory, strategy and practice.

1.1 Introduction

Community-centred approaches have emerged as central tenets within Public Health policy and strategy to improve health and reduce health inequalities. The Declaration of Alma Ata (World Health Organisation (WHO), 1978) and the Ottawa Charter (WHO, 1986) promoted an agenda for increasing participation, empowerment and community action (WHO, 2009), and were instrumental in the shift towards community-centred approaches in health promotion (Laverack & Wallerstein, 2001; Laverack, 2004; Liberato, Brimblecombe, Ritchie, Ferguson & Coveney, 2011; Bauman & Nutbeam, 2014).

The emphasis on community approaches has expanded as understanding of the social and environmental determinants of health has increased and the prevalence of obesity and associated comorbidities has emerged as a primary public health concern (Bauman & Nutbeam, 2014; Navarro, Voetsch, Liburd, Giles & Collins, 2007; Merzel & D'Afflitti, 2003; Wallerstein, 2002). Current UK strategies reflect the move towards an ecological framework for health, calling for integrated multi-pronged and place-based approaches, partnerships, and mobilisation of local assets to empower and build resilient individuals and communities (Department of Health (DoH), 2010; National Institute for Health and Care Excellence (NICE), 2012, 2016; Public Health England (PHE), 2014, 2015). Community-centred interventions focussing on dietary and obesity related behaviours are at the forefront of health promotion (Brandsetter, Rütter, Curbach & Loss, 2015).

Despite interest in community and empowerment approaches, there remains a gap between academic discourse, policy and practice (Bertotti, Jamal & Harden, 2012; Wallerstein, 2002; Adamson & Bromiley, 2013). PHE (2015) suggested that the diversity of community practise in England is not sufficiently reflected in the evidence base used to drive strategy, policy and future practice; and emphasised the need for practitioners to "be prepared to evaluate" (p.6). This literature review therefore explores understanding and trends in evaluation of health promotion interventions; and considers how community, empowerment and associated constructs are conceptualised, to better understand how these may be operationalised and evaluated within practice.

1.2 Health Promotion Evaluation

Health promotion evaluation has developed as an area of research interest, and as an important strategy to improve and inform practice (Lobo, Petrich & Burns, 2014, Bauman & Nutbeam, 2014). Stakeholders involved in the design and delivery of health promotion interventions have been, and continue to be, under increasing pressure to justify investment in services, and to demonstrate that services are effective and efficient (Habicht, Victora & Vaughan, 1999; National Obesity Observatory (NOO), 2009; WHO European Working Group on Health Promotion Evaluation, 1998).

An intervention may be defined as a set of actions with an objective to bring about identifiable outcomes, and may include local single strategy projects or multicomponent programmes (Rychetnik et al., 2002). An intervention consists of several stages, each of which are influenced by a complex set of factors, priorities and decisions that

can impact the efficacy and fidelity of the intervention process, and contribute to the contextually specific nature of each intervention. Mitchie et al. (2008) and NOO (2009) provide useful frameworks to understand the multiple stages in the process of an intervention (Figure 1).

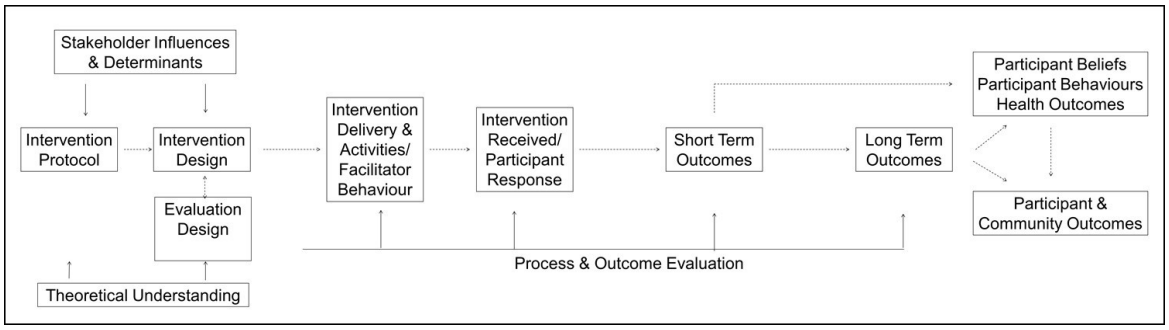

Figure 1. Conceptual Diagram of the Intervention Process and Influences on Design (adapted from Mitchie et al., 2008; NOO, 2009)

The design and implementation of evaluation, itself, may be influenced by who requires the evaluation and what their priorities are. In practice, service providers often focus on evaluating adequacy of an intervention (Habicht, Victora & Vaughan, 1999). Lobo et al. (2014) discuss organisational (funding, duration, setting), capacity (skills and knowledge) and translational factors (limitations on opportunities to convert knowledge and skills) that impact the ability of evaluation to identify what works well and why.

Whilst evaluation is carried out for various purposes, a central purpose, is to determine an intervention's effectiveness, to identify successful techniques, and inform future policy and practice. This view aligns with calls for fuller and more detailed evaluation and reporting of interventions to expand the evidence base related to the design, implementation and evaluation of health promotion interventions

(Mitchie et al., 2008; Rychetnik, Frommer, Hawe & Shell, 2002; Jolley, 2014; Lobo et al., 2014).

Judd, Frankish and Moulton (2001) define evaluation as the "comparison of an object of interest against standards of acceptability" (p368). The WHO European Working Group (1998) defined evaluation as "the systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness" (p.3). The latter recommended that both process and outcomes of initiatives should be evaluated and that participatory approaches should be encouraged. Additionally, the report recommended use of appropriate and multiple methods to evaluate the complexity of interventions. The importance placed on evaluation was emphasised by the recommendation to allocate 10% of resources in an intervention to evaluation.

Process evaluation measures what or how a programme works rather than if a programme works, and is advocated as an important element of evaluating health promotion (Saunders, Evans & Joshi, 2005; WHO European Working Group, 1998; PHE, 2015b). Process evaluation often focuses on satisfaction and indicators of participation following recommendations given in Standard Evaluation Frameworks (SEF), (NOO, 2009, 2012); these may not answer why or how an intervention works but may determine if interventions are meeting objectives.

Mitchie et al., (2011) have suggested that published reports tend to provide limited details of intervention content, and point to inconsistency in terminology impacting the potential for comparability and replicability across studies. They argue that more

standardised definitions of intervention techniques are needed to enable effective mapping of techniques across theoretical constructs and practice; and to enable comparison of evidence that may improve understanding of how interventions work.

Frameworks enable collection of specific data related to an intervention, and offer a systematic approach to improving the description and evaluation of community-centred health interventions. Various SEF's are available listing criteria for inclusion in evaluation (NOO, 2009; NOO, 2012). Mitchie et al. (2011) provide a set of forty criteria for describing and evaluating behaviour change interventions. The Guide for Effective Nutrition Interventions and Education (GENIE) provides a validated set of nine categories (thirty-five criteria) as evidence based indicators for positive outcomes in nutrition education programmes (Hand et al., 2015; Abram et al., 2015). Saunders et al. (2005) and Van Daele, Van Auden Hove, Herman, Van Den Bergh, and Van Den Broucke (2012) suggest step-wise approaches incorporating elements such as fidelity, dose, reach and context to facilitate process evaluation.

Despite the growth in interest in evaluation as a subject area, and in availability of tools that seeks to determine the effectiveness and efficacy of health promotion interventions, the evidence of what works, why and how remains elusive, with heterogeneity in the available data and findings. Nutritional health promotion programmes are typically evaluated using anthropometric, physiological and dietary outcome measures (Contendo, Randall & Bach, 2002; Brandstetter et al., 2015).

There is a growing acceptance of, and move towards, non-traditional measures of success, mixed, and qualitative methods within public health evaluation (Bauman &

Nutbeam, 2014; Braithwaite et al., 2013; Jolley, 2014). Inclusion of data related to programme implementation, delivery, participation, and response, to enable a multi-level description of service delivery that may help explain outcome measures is recommended (Lipsey & Cordray, 2000; Wagemakers, Vaandragar, Koela, Saan & Leeuwis, 2010). Judd et al. (2001) suggest benefits in adopting an approach that considers a wide range of strategies, indicators and interests that can measure the fidelity of an intervention and can measure the unanticipated as well as the anticipated outcomes. Combining systematic and flexible evaluation may offer the most appropriate approach to evaluate the variability within community-centred interventions (Lipsey & Cordray, 2000; Braithwaite et al., 2013; Wagemakers et al., 2010).

1.3 Community-Centred Health Promotion

The WHO European Working Group (1998) highlighted the need for health promotion initiatives to be "empowering, participatory, holistic, inter-sectoral, equitable, sustainable, and multi-strategy" (p.3). The use of these terms has become part of the every-day vocabulary within health promotion (Wallerstein, 2006). Despite trends in adoption, or claims to adopt, empowerment, participatory and community approaches within nutrition and health promotion interventions, there is little evidence of how these are implemented or evaluated. They remain contested concepts, with ambiguity in how they are defined and applied. Evidence of links between these approaches and health outcomes has mainly emerged from research within development studies and projects with marginalised groups (women, mental health and social care, HIV), (Rifkin,

2014; Wallerstein, 2006; Brandstetter et al., 2015; Woodall, Raine, South & Warwick-Booth, 2010; Laverack & Wallerstein, 2001). These reviews all highlight the need to clarify how empowerment, community and participation are conceptualised, and unpick the relationships between them, in order that these approaches can be operationalised or evaluated.

1.3.1 Community as a Concept

Community as a research area has its roots in the social sciences, such as sociology, political or development studies (Bertotti et al., 2012). Historically community has been considered as relating to location or place. As Bertotti et al. (2012) assert understandings of community have emerged and evolved in response to changes in political, social, cultural and economic developments. Within the UK community care is defined as care in a non-hospital setting, and came to prominence in the 1990's along with patient empowerment. Use of the terms community and empowerment within social care and mental health is context specific and politically driven; and arguably has added to a misleading use of these terms within healthcare (Jack, 1995).

Community has become more defined by activity, purpose and commonalities in interest, as population densities and diversification of roles has increased. It is this definition that is often adopted in disciplines such as education, organisational studies or political studies, where the focus is on shared goals and values. Community defined in this way is diverse and transient (Bertotti et al., 2012).

Bracht, Kinsburg and Rissel (1999) suggest that community development emerging from the fields of social work and international development, underpinned the

community based health promotion movement of the 1980s and 1990s. In community development, the focus is on community capacity, action and mobilization (Bracht, 1999). Berotti et al. (2012) discuss community mobilization as collective action that gives a voice to marginalized people. In health promotion, this conceptualisation of community tends to be associated with participation, capacity-building, empowerment, equity and sustainability (Judd et al., 2011; Laverack, 2016).

McLeroy, Norton, Keglar, Burdine and Sumaya (2003) suggest that changing community capacity may offer the best potential for effectiveness of community based health promotion, and that this requires a shift in focus of interventions from individual behaviour change to building communities. Community capacity is here seen as both a desired outcome and a resource for change or action.

From a sociological point of view community is concerned with relationships and interactions between people. Recent developments such as globalisation and technology have led to a further diversification of how community is defined. Thompson and Kinne (1999) note that a community requires some social connectivity and social organisation for social norms and control to be communicated between members, suggesting that internet based communication has changed the way a community is conceptualised. Bertotti et al. (2012) describe internet based communities as "thin" communities, differentiating them from "thick" communities that are based on common identities and location (p.7).

McLeroy et al. (2003) provide a typology of community that distinguishes between community as a setting, target, agent or resource. They suggest that community as a

resource reflects the important role of community ownership and participation in achieving sustainable population level health outcomes. Community as agent aligns with the emerging interest in health assets and salutogenic approaches that seek to utilise naturally occurring social connections and health assets within communities to bring about improvements in health behaviours and outcomes (Lindstrom & Eriksson, 2005; Glasgow Centre for Population Studies, 2011).

Merzel and D'Afflitti (2003) note that community health interventions typically refer to community as the intervention's setting, and that this is typically framed in terms of location and/or target groups. In the UK Public Health is regionally structured; PHE (2015) suggests decentralisation provides opportunities for more community-centred approaches. PHE (2015) and NICE (2016) define community as both place-based and where people share common goals or affinity, highlighting that community-centred approaches are more than simply community-based.

A full definition of community may then need to acknowledge spatial (place) dimensions and non-spatial (shared interests and identities), as well as the social interactions that link individuals and enable collective action (Liberato et al., 2011; Laverack, 2016). Thus, any evaluation of a community-centred intervention must define the community in its broadest sense and include a consideration of place, setting, target, social interactions, and assets or resources; and must distinguish between community-based, community-led or community-mobilisation strategies.

1.4 Empowerment within Health Promotion

The Ottawa Charter (WHO, 1986) is frequently cited as a defining document that has underpinned the move towards participatory and empowerment approaches in health promotion since the 1980's (Bracht, 1999; Grace, 2013; Woodall, Warwick-Booth & Cross, 2012; Bauman & Nutbeam, 2014; Wallerstein, 2002, 2006). The Declaration defined health promotion as a "process of enabling people to take control over their health and its determinants and thereby improve their health" (WHO, 1986, cited in WHO, 2009, p.25); and identified strengthening community action and developing personal skills as two of the key points for action. The Jakarta Declaration in 1997 reaffirmed the Ottawa Charter and referred to the important role of settings, families, neighbourhoods and communities and opportunities for participation in health promotion (WHO, 2009). Bracht (1999) suggested that these two documents put capacity building and local empowerment at the centre of community-based health promotion.

The use of empowerment as a term is hotly criticised. Woodall et al. (2012) have suggested the lack of clarity in how empowerment is defined has led to a "dilution from its original roots as a radical social movement" (p.742). They further question whether empowerment has simply become a buzz word. Popularisation of the term is criticised for leading to a vague and inconsistent conceptualisation, used to legitimize top-down policies and programmes with little understanding of how empowerment is operationalised within interventions (Calves, 2009; Grace, 2013).

1.4.1 Defining Individual and Community Empowerment

Empowerment is used and defined differently across disciplines; power though is a fundamental element (Wallerstein, 2002, 2006). The WHO European Working Group (1998) defined empowerment as enabling "individuals and communities to assume more power over the personal, socioeconomic and environmental factors that affect their health" (annex 2 p.8). Rappaport (1984) is frequently cited, defining empowerment as "the mechanism by which people, organisations and communities gain mastery over their own lives" (P.7). The English Oxford Dictionary (2016) defines empowerment as giving someone authority or power; it refers to making someone stronger or confident in controlling their lives and claiming their rights.

Much of the discourse on empowerment centres on how empowerment is perceived in terms of power relations, and how it is perceived as an outcome or process (Laverack, 2006; Grace, 2013; Woodall et al., 2012; Wallerstein, 2006). One of the key criticisms of its use in health promotion is that power is not something that can be given to another (Grace, 2013).

In the 1970s and 1980s empowerment emerged in the rhetoric of international development studies and programmes; associated with political mobilization and empowerment of marginalised, repressed or minority groups (Calves, 2009; Lincoln, Travers, Ackers & Wilkinson, n.d.). In political terms, individual empowerment is often linked to consumer rights and the right to choose. In Public Health this is perhaps most evident in patient empowerment that emerged as a strategy to enable people to

make choices and exert their rights over the management of their healthcare (Laverack, 2016; Brandstetter et al., 2015).

1.4.2 Individual Empowerment

Laverack (2016) differentiates between empowerment as a process by which people gain power over decisions and resources that influence their lives and an outcome as a change in the distribution of authority or decision making. Individual empowerment is often described as gaining power from within as a process of increasing self-esteem, -efficacy, -determination or autonomy (Laverack, 2016). Autonomy, or agency (the capacity to make meaningful choices), though requires more than just self-efficacy, it requires underpinning knowledge and competencies. Differing forms of empowerment described include intellectual empowerment (increased knowledge and expectations), experiential empowerment (capacity to control behaviours), and psychological empowerment (perception of greater control) (Lincoln et al., n.d; Bracht et al., 1999).

Health education and communication, to raise awareness and inform, is an established strategy in health promotion. Health literacy is a concept that has emerged, and is concerned with development of skills and confidence to enable people to make informed decisions and choices in relation to their health (capacity-building) (Nutbeam, 1998; Liberato et al., 2011). According to Laverack (2016), empowerment education goes beyond increasing knowledge or awareness and seeks also to increase critical reflection.

Woodall et al. (2012) suggest that it is the emergence of empowerment from multiple disciplines and the focus on individual empowerment within health promotion that has contributed to the lack of clarity in defining and conceptualising empowerment.

1.4.3 Community Empowerment

Community empowerment is the process by which communities develop towards collective or social action to address issues of concern. In a development context, this has tended to include a redistribution of power, resources or decision making and is viewed as the interaction between collective capacities to make choices and bring about positive outcomes within the social and institutional context (Bracht et al., 1999; Walton, 2003). Adamson (2010) and Adamson and Bromiley (2013) make a distinction between community empowerment and community engagement. Laverack (2016) suggests community empowerment requires capacity building at the individual and community level as well as collective action, and can be regarded as a continuum (Figure 2). Rissel (1994) presented a similar continuum, though as a more complex set of relationships than the linear model depicted in figure 2.

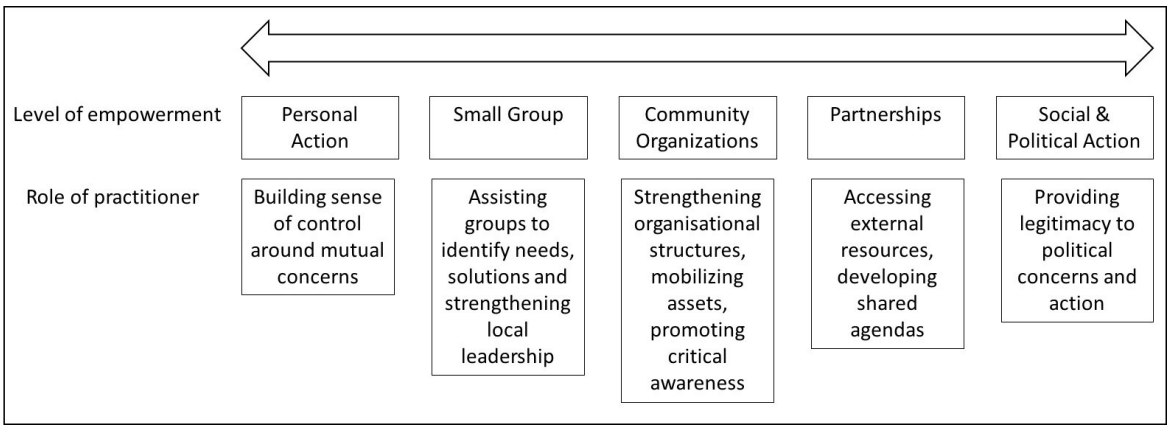

Figure 2. Community Empowerment as a 5-point Continuum (adapted from Laverack, 2016)

The relationship between individual and community empowerment is complex. Individual empowerment is considered as crucial in facilitating community empowerment (Wallerstein, 2006; Rawlett, 2014; Woodall et al. 2010; Laverack, 2016). Rawlett (2014) suggests that individual self-efficacy is more likely to bring about individual action, and lead to individual and community empowerment.

Community empowerment is also seen as enabling individuals to become empowered. Participation in community-based action is recognised as promoting individual efficacy, greater sense of community, greater understanding of power relationships and a greater willingness to participate in collective action (Bracht et al., 1999; Wallerstein, 2006). The processes of individual empowerment and community empowerment may, therefore, be both dependent on each other and mutually reinforcing.

1.5 Participatory Approaches

Shemmings and Shemmings (1995) suggested that participation is a better word to use in place of empowerment. Certainly, participation is advocated as a central tenet of empowerment and community-centred approaches.

Participation can take many different forms and different roles. Various models of participation exist that suggests a continuum of participation from tokenism and manipulation through involvement and partnership to citizen control (Ruderman, 2000). Participation is typically characterised as involving all stakeholders; defining their own needs, solutions and actions; being involved in decision making at the planning, implementation and evaluation stages; free flow of information between all

stakeholders; and fostering an empowering relationship between professionals and participants (Laverack, 2016; WHO European Working Group, 1998).

PHE (2015) and NICE (2016) emphasise the importance of participatory approaches, engagement through volunteering, and utilizing community assets and resources, to build community capacity and improve health. Laverack (2006) suggests that strengthened social networks and social support, built through improved/increased relationships between practitioners and participants, and between participants themselves, brings about beneficial health outcomes.

Participation has also been criticised for being poorly defined. Rifkin (2014) has reviewed evidence from a range of interventions linking participation to health outcomes and concludes that evidence remains elusive due to differences in how participation and community are defined and the specificity of interventions; claiming a need to consider more closely issues of empowerment, ownership and sustainability.

1.6 Common Constructs

Despite the ambiguity in defining empowerment, community and participation a review of the literature suggests several common concepts including personal development, participation, consciousness raising and capacity building, shared values and needs, and social networks (Rissel, 1994; Bracht et al., 1999; Ruderman, 2000; Wallerstein, 2006; Liberato et al., 2011; Woodall et al., 2010) (see Table 1). Laverack's (2016) nine domains of community empowerment (community participation, local leadership, organisational structures, problem assessment, resource mobilization, reflection, partnerships, relationship/role of outside agents and programme

management) have become an established part of empowerment strategies. Woodall et al. (2010) discuss an empowerment model that incorporates building confidence, building capacity and systems challenge.

Based on the constructs identified, the role of the practitioner within health promotion interventions may be in raising awareness and knowledge, developing skills and competencies, increasing health literacy and confidence (i.e. capacity building) (Woodall et al., 2010; Laverack, 2006). It may also be in providing opportunities to develop partnerships, participation and a sense of community (Adamson, 2010; Adamson & Bromiley, 2003). Jack (1995) suggested that strategies often considered as empowering may be more accurately conceptualised as enabling, or creating opportunities that promote participation, involvement and development.

Table 1: Common Constructs Associated with Empowerment and Community-centred Approaches in Health Promotion

Common Constructs	(Laverack, 2016; Laverack & Wallerstein, 2001)	Ruderman (2000)	Shediac-Rizkallah & Bone (1998)	(Liberato et al., 2011)	(Woodall et al., 2010)	Allsop & Heinsohm (2005)	Wallerstein (2002, 2006)
Participation	Participation	Participation (consultative to active involvement), ownership	Participation, Involvement, Ownership	Participatory decision making			Community action/ participation: meaningful, decision-making, use of lay leaders, leadership/advocacy
Partnerships, social capital & networking	Partnerships, Relationship with outside agents	Social capital (trust, cooperation, engagement) Opportunities for networking, sense of membership		Partnerships and networking, Sense of community, Communication	Sense of community, broadened social networks & social support	Social capital & networks	Supportive environments: supportive groups, dialogical approach, based on indigenous knowledge
Capacity-building Individual & community capacity & competencies	Local leadership, Resource mobilization Reflection	Community capacity (commitment, resources, skills, participation, sense of community, critical reflection), Community competence (communication, relationship management, participation, leadership development), Empowerment (participation, mobilization, ownership)	Capacity building, Competence	Skills development & learning opportunities, Resource mobilization, Leadership development, Assets-based approaches, Commitment to action, Development pathway	Building confidence, Building capacity Improved self-esteem or self-efficacy Greater sense of control Increased knowledge and awareness Behaviour change	Agency / Capacity building Health literacy/skills Self-belief	Personal skills: planning/actions, access to information Critical reflection
Programme management and organisational approaches	Programme management, Problem assessment, Organisational structures,	Community (common values, goals & needs),		Community needs assessment Shared vision & goals Dissemination Process outcome monitoring	Systems challenge	Opportunities for choice	Healthy public policy: collective actions, transfer power, effective organization structures & capacity, transparency, Reorienting health care

1.7 Evaluating Empowerment and Community Approaches

Lack of clarity in how empowerment, participation and community are conceptualised and applied in practice makes evaluation and measurement difficult (Woodall et al., 2010). Community health promotion interventions tend to be short term and targeted to specific groups; making it more difficult to measure empowerment outcomes that may develop over the longer term and sustainability of outcomes (Laverack & Wallerstein, 2001).

A sense of ownership and power is advocated as a necessary part of empowerment. Health interventions are typically planned, designed and implemented by professional agencies and practitioners and are therefore determined by an embedded top-down approach; leading to an apparent contradiction between the emancipatory discourse and practise within programmes (Laverack, 2004, Laverack, 2016).

Individual measures such as self-efficacy are easier to measure as a proxy for individual empowerment. Thompson and Kinne (1999) suggest that change at the individual level can be determined by evaluating participants' awareness of the intervention, their knowledge of topics covered, levels of participation and any changes in behaviour.

Braithwaite et al. (2013) list several of the identified constructs (Table 1) as proxy measures for evaluating participation and engagement. Community change may be evaluated by indicators of social connectedness and evidence of changes in the norms and values at the sub-system or community-wide level (Thompson & Kinne, 1999). Allsop and Heinsohm (2005) provide a Measuring Empowerment (ME) framework

based on indicators of agency (capacity to choose), opportunities for choice, and use of or outcomes of choices. The framework also includes indicators for the level of empowerment defined as local, intermediary and macro; civic, market and social action.

Laverack (2004) and Laverack and Wallerstein (2001) suggests the nine empowerment domains provide an appropriate tool to implement and evaluate empowerment. These are incorporated into a framework for parallel tracking, in which constructs and techniques related to empowerment are considered in parallel to techniques and methodologies embedded in health promotion intervention practice (Laverack & Labonte, 2000; Laverack, 2016). A similar approach is advocated by Van Daele et al. (2012). Applying criteria identified in these frameworks may be a valid approach to evaluate interventions that include empowerment amongst their goals and objectives.

Collaborative and participatory action research are advocated within community development and empowerment evaluation (WHO European Working Group, 1998; Van Daele, 2012). Participatory evaluation is perceived as more likely to reflect measures of empowerment, and serves as an empowering process itself (Judd et al., 2001). However, participatory approaches to evaluating health promotion interventions has many challenges (Israel, Schultz, Parker, & Becker, 1998; Bracht, 1999).

1.8 Conclusion

Implementation and evaluation of empowerment and community-centred approaches within health promotion may be hampered by a lack of clarity in their conceptualisation and application. The discussion on empowerment highlights the challenges in adopting an empowerment approach; the extent to which, and how, professionally led health promotion interventions empower participants remains unclear. Community-centred health promotion interventions are complex and highly context specific. Their design, delivery and evaluation may be constrained, or at least influenced, by the reality of funding, resources, setting, or stakeholder priorities and knowledge (Bracht, 1999).

Despite the extensive literature that has debated empowerment, community-centred approaches and evaluation, there remains a gap between theory, strategy and practice (Bertotti et al., 2012; Wallerstein, 2002; Adamson & Bromiley, 2013; Woodall et al., 2010). The limited evidence from practice highlights the need for more evaluation and reporting of interventions (PHE, 2015; Lobo et al., 2014).

The growing acceptance that a combination of investigative methods is needed to evaluate what works in practice, provides an opportunity to draw on a wider range of methodologies that may support more detailed process evaluation (Lipsey & Cordray, 2000; Saunders et al., 2005). Exploring evidence from practice may elicit insights into how best to operationalise and evaluate the wider, and harder to measure, health benefits associated with community and empowerment approaches. With community-centred approaches advocated as key strategies to tackle current public health

concerns (PHE, 2014, 2015; NICE, 2016), evaluating what happens in practice may be the best approach to identify effective techniques and to close the gap between theory and practice.

References

Abram, J.K., Hand, R.K., Parrott, J.S., Brown, K., Ziegler, P.J., & Steiber, A.L. (2015). What Is Your Nutrition Program Missing? Finding Answers with the Guide for Effective Nutrition Interventions and Education (GENIE). *Journal of the Academy of Nutrition and Dietetics, 115(1)*: 122-130, doi: 10.1016/j.jand.2014.08.024

Adamson, D. (2010). Community Empowerment. *International Journal of Sociology and Social Policy, 30(3/4):* 114 – 126, doi: 10.1108/01443331011033319

Adamson, D. & Bromiley, R. (2013). Community Empowerment: Learning from Practice in Community Regeneration. *International Journal of Public Sector Management, 26(3):* 190-202, doi: 10.1108/IJPSM-08-2011-0105

Allsop, R. & Heinsohm, N. (2005). *Measuring Empowerment in Practice: Structuring Analysis and Framing Indicators.* World Bank Policy Research Working Paper 3510, February 2005.

Bauman, A. & Nutbeam, D. (2014). Planning and Evaluating Population Interventions to Reduce Non-Communicable Disease Risk – Reconciling Complexity and Scientific Rigour? *Public Health Research & Practice, November 25(1):* e2511402, doi: 10.17061/phrp2511402

Bertotti M., Jamal, F., & Harden, A. (2012). *A Review of Conceptualisations and Meaning of 'Community' within and across Research Traditions: A Meta-Narrative Approach.* London: AHRC

Bracht, N., Kingsburg, L. & Rissel, C. (1999). *A Five Stage Community Organisation Model for Health Promotion Empowerment and Partnership Strategies* Ch.4 in Bracht, N. (Ed) (1999). *Health Promotion at the Community Level New Advances (2nd Edition).* California: Sage Publications Inc.

Bracht, N. (Ed) (1999*). Health Promotion at the Community Level New Advances (2nd Edition).* California: Sage Publications Inc.

Braithwaite, R.L., McKenzie, R.D., Pruitt, V., Holden, K.B., Aaron, K., & Hollimon, C., (2013). Community-Based Participatory Evaluation: The Healthy Start Approach. *Health Promotion Practice, 14(2):* 213–219, doi: 10.1177/1524839912443241

Brandstetter, S., Rüter, J., Curbach, J. & Loss, J. (2015). Review Article: A Systematic Review on Empowerment for Healthy Nutrition in Health Promotion. *Public Health Nutrition, 18(17):* 3146–3154, doi: 10.1017/S1368980015000270

Calves, A.E. (2009). Empowerment: The History of a Key Concept in Contemporary Development Discourse. *Revue Tiers Monde, 2009/4(200):* 735-749, doi: 10.3917/rtm.200.0735

Contendo, I.R., Randell, J.S., & Basch, C.E. (2002). Review and Analysis of Evaluation Measures Used in Nutrition Education Intervention Research. *Journal of Nutrition Education and Behavior, 34(1):* 2-25

Department of Health (DoH) (2010). *Healthy Lives, Healthy People: Our Strategy for Public Health in England.* London: Department of Health. Accessed 20 May 2016 from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

English Oxford Dictionary (2016) *Empowerment*. Oxford University Press. Accessed 18 August 2016 from http://www.oxforddictionaries.com/definition/english/empower

Glasgow Centre for Population Studies (2011). *Asset Based Approaches for Health Improvement: Redressing the Balance.* Glasgow Centre for Population Studies Concept Series 9 (October 2011).

Grace, S. (2013). *Empowerment, Health Promotion and Young People: A Critical Approach.* Florence, GB: Routledge.

Habicht, J.P., Victora, C.G. & Vaughan, J.P. (1999). Evaluation Designs for Adequacy, Plausibility and Probability of Public Health Programme Performance and Impact. *International Journal of Epidemiology, 28:* 10-18

Hand, R.K., Abram, J.K., Brown, K., Ziegler, P.J., Parrott, J.S., & Steiber, A.L. (2015). Development and Validation of the Guide for Effective Nutrition Interventions and Education (GENIE): A Tool for Assessing the Quality of Proposed Nutrition Education Programs. *Journal of Nutrition Education and Behavior, 47(4*): 308-316, doi: http://dx.doi.org/10.1016/j.jneb.2015.03.003

Israel, B.A., Schultz, A., Parker, J. & Becker, A.B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health,* 19: 173-202

Jack, R. (Ed) (1995). *Empowerment in Community Care*. California: Chapman and Hall.

Jolley, G. (2014). Evaluating complex community-based health promotion: Addressing the challenges. *Evaluation and Program Planning, 45:* 71–81, doi: 10.1016/j.evalprogplan.2014.03.006

Judd, J., Frankish, C.J. & Moulton, G. (2001). Setting Standards in the Evaluation of Community-Based Health Promotion Programmes – A Unifying Approach. *Health Promotion International, 16(4):* 367-380

Laverack, G. (2004). *Health Promotion Practice Power and Empowerment.* London: Sage Publications.

Laverack, G. (2006). Improving Health Outcomes through Community Empowerment: A Review of the Literature. *Journal Health Population Nutrition, 24(1):* 113-120

Laverack, G. (2016) *Public Health, Power, Empowerment and Professional Practices. 3rd Edition*. London: Palgrave.

Laverack, G. & Labonte, R. (2000). A Planning Framework for Community Empowerment Goals within Health Promotion. *Health Policy and Planning, 15(2):* 255-262

Laverack, G. & Wallerstein, N. (2001). Measuring Community Empowerment: a Fresh Look at Organisational Domains. *Health Promotion International, 16(2):* 179-185

Liberato, S.C., Brimblecombe, J., Ritchie, J., Ferguson, M. & Coveney, J. (2011). Measuring Capacity Building in Communities: a Review of the Literature. *BMC Public Health, 11:* 850- 859

Lincoln, N.D., Travers, C., Ackers, P. & Wilkinson, A. (n.d.). *The meaning of empowerment: The new interdisciplinary etymology of a new management concept.* Loughborough University.

Lindström B, & Eriksson M. (2005). Salutogenesis. *Journal of Epidemiology and Community Health,* 59(6):440-442, doi: 10.1136/jech.2005.034777

Lipsey, M.W. & Cordray, D.S. (2000). Evaluation Methods for Social Intervention, *Annual Review of Psychology, 51*: 345-375

Lobo, R., Petrich, M. & Burns, S.K. (2014). Supporting Health Promotion Practitioners to Undertake Evaluation for Programme Development. *BMC Public Health, 15:1315:* 1-8, doi: 10.1186/1471-2458-14-1315

McLeroy; K.R., Norton, B.L., Keglar; M.C. Burdine, J.N., & Sunaja, C.V. (2003). Editorial April 2003. *American Journal of Public Health, 93(4):* 529-533

Merzel, C. & D'Afflitti, J. (2003). Reconsidering Community-Based Health Promotion: Promise, Performance, and Potential. *Public Health Matters, American Journal of Public Health 93(4):* 557-574

Mitchie, S., Ashford, S., Sniehotta, F.F., Dombrowski, S.U., Bishop, A. & French, D.P. (2011). A Refined Taxonomy of Behaviour Change Techniques to Help People Change their Physical Activity and Healthy Eating Behaviours: The CALORE Taxonomy. *Psychology & Health, 26(11)*: 1479-1498, doi: 10.1080/08870446.2010.540664

Mitchie, S., Hardman, W., Fanshawe, T., Prevost, A.T., Taylor, L. & Kinmonth, A.L. (2008). Investigating Theoretical Explanations of Behaviour Change: The case Study of ProActive. *Psychology & Health, 23(1):* 25-29, doi: 10.1080/08870440701670588

National Institute for Health and Clinical Excellence (NICE) (2012). *Obesity: Working with Local Communities*. London: NICE Guidelines [PH42]

National Institute for Health and Clinical Excellence (NICE) (2016). *Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities.* London: NICE Guidelines [NG44]

National Obesity Observatory (NOO) (2009). *Standard Evaluation Framework for Weight Management Interventions.* Oxford: The National Obesity Observatory.

National Obesity Observatory (NOO) (2012). *Standard Evaluation Framework for Dietary interventions.* Oxford: The National Obesity Observatory.

Navarro, A.M., Voetsch, K.P., Liburd, L.C., Giles, H.W., & Collins, J.L. (2007). Charting the Future of Community Health Promotion: Recommendations from the National Expert Panel on Community Health Promotion. *Preventing Chronic Disease [serial online], 4(3):* 1-7, Available from: http://www.cdc.gov/pcd/issues/2007/ jul/07_0013.htm.

Public Health England (PHE) (2014). *From Evidence in to Action: Opportunities to Protect and Improve the Nation's Health.* October 2014 London: PHE Publications Gateway Number: 2014404

Public Health England (PHE) (2015). *A Guide to Community-Centred Approaches Full Report.* London: PHE Publications Gateway Number: 2014711

Public Health England (PHE) (2015b). *Evaluation of Weight Management, Physical Activity and Dietary Interventions: An Introductory Guide*. London: PHE Publications Gateway Number: 2015090

Rappaport, J. (1984) *Studies in Empowerment: Introduction to the Issue*. P.1-7 in Rappaport, J., Swift, C. & Hess, R. (Eds) *Studies in Empowerment: Steps Towards Understanding and Action. Prevention in Human Services 3(2/3).* London: Routledge

Rawlett, K.E. (2014). Journey from Self-Efficacy to Empowerment. *Health Care, 2(1*): 1-9, doi: 10.12966/hc.02.01.2014

Rifkin, S.B. (2014) Examining the links between community participation and health outcomes: a review of the literature. *Health Policy and Planning 29:* ii98-ii106 doi: 10.1093/heapol/c2uo76

Rissel, C. (1994). Empowerment: The holy grail of health promotion? *Health Promotion International, 9(1):* 39-47

Ruderman, M. (2000). *Resource Guide to Concepts and Methods for Community-Based and Collaborative Problem Solving.* Baltimore MD: Women's and Children's Health Policy Center Department of Population and Family Health Sciences Johns Hopkins University Bloomberg School of Public Health.

Rychetnik, L., Fromer, M. Hawe, P. & Shiell, A. (2002). Criteria for Evaluating Evidence on Public Health Interventions. *Journal of Epidemiology Community Health, 56:*119–127

Saunders, R.P., Evans, M.H., & Joshi, P. (2005). Developing a Process Evaluation Plan for Assessing Health Promotion Program Implementation: A How to Guide. *Health Promotion Practice, 6(2)*: 137-147, doi: 10.1177/1524839904273387

Shediac-Rizkallah, M.C. & Bone, L.R. (1998). Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research 13(1):* 87-108

Shemmings, D. & Shemmings, Y. (1995). Defining Participative Practice in Health and Welfare. In Jack, R. (Ed) (1995). *Empowerment in Community Care*. California: Chapman and Hall.

Thompson, B. & Kinne, S. (1999). *Social Change Theory Applications to Community Health* Ch 2 in Bracht, N. (Ed) (1999) *Health Promotion at the Community Level New Advances (2nd Edition).* California: sage Publications Inc.

Van Daele, T., Van Auden Hove, C., Herman, D., Van Den Bergh, O. & Van Den Broucke, S. (2012). Empowerment implementation: enhancing fidelity and adaptation in a psycho-educational intervention. *Health Promotion International, 29(2):* 212-222. doi: 10.1093/heapro/das070

Wagemakers, A., Vaandrager, L. Koelen, M.A., Saan, H. & Leeuwis, C. (2010). Community Health Promotion: A Framework to Facilitate and Evaluate

Supportive Social Environments for Health. *Evaluation and Program Planning, 33:* 428-435, doi: 10.1016/j.evalprogplan.2009.12.008

Wallerstein, N. (2002). Empowerment to Reduce Health Disparities. *Scandinavian Journal Public Health, 30:* 72-77

Wallerstein, N. (2006) *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen, WHO Regional Office for Europe. Health Evidence Network Report. Accessed 9 June 2016 from http://www.euro.who.int/Document/E88086.pdf

Walton, M. (2003). *Notes on Empowerment, presented at the Workshop on "Measuring Empowerment: Cross-Disciplinary Perspectives" at the World Bank,* Washington, DC February 4 & 5, 2003.

Woodall, J., Raine, G., South, J. & Warwick-Booth, L. (2010*). Empowerment and Health & Well-Being Evidence Review.* Centre for Health Promotion Research, Leeds Metropolitan University.

Woodall, J.R., Warwick-Booth, L. & Cross, R. (2012). Has Empowerment Lost its Power? *Health Education Research, 27(4):* 742-745, doi:10.1093/her/cys064

World Health Organisation (WHO) (1978). *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

World Health Organisation (WHO) (1986). *Ottawa Charter for Health Promotion.* Geneva: WHO

World Health Organisation (WHO) European Working Group on Health Promotion Evaluation (1998). *Health Promotion Evaluation: Recommendations to Policy-Makers Report of the WHO European Working Group on Health Promotion Evaluation.* EUR/ICP/IVST 05 01 03

World Health Organization (2009). *Milestones in Health Promotion: Statements from Global Conferences.* Geneva: WHO

Department of Clinical Sciences and Nutrition

MSc Public Health Nutrition

Research Report

Project Title: Evaluating Practice within a Community Health Promotion Intervention – What is the Evidence for Successful Techniques, Empowerment and Community-Centred Approaches?

(Key Words: Evaluation, Community-Centred Approaches, Empowerment, Practice)

Name: Judith Fynn

Assessment Number: J21398

Date Submitted: 31 October, 2016

Word Count: 4574

Contents

Table of Tables

Table of Figures

1. Rationale for Publication

Health Education Research is a peer reviewed journal publishing articles on both theoretical processes and practical implementation. Priority is given to research focused on health education and health promotion, particularly intervention studies. The focus of this study was to explore practice within a community-based health promotion intervention, to elicit insights that may help to close the gap between theoretical discourse and practical implementation; and to explore the value of adopting different methods to evaluate complex community interventions. This study may, therefore, be of interest to the readership of Health Education Research, and it is considered an appropriate journal for publication.

2. Abstract

Background and Aims: Community-centred interventions are an important health promotion strategy to tackle current public health concerns. Community and empowerment approaches are complex to conceptualise, operationalise and evaluate. The present study evaluated a short (five week), community-based healthy eating intervention delivered to parents and guardians of children aged one to four years to explore evidence of techniques and processes implemented within the intervention.

Methods: The study combined interviews with facilitators and observations of intervention delivery with analysis of organisational documentation and existing evaluation data. Iterative data collection and analysis, and triangulation, allowed a detailed description and critical process evaluation.

Results: There was fidelity across the intervention design, delivery and evaluation processes, in content (developing awareness, knowledge and skills related to nutritional messages) and techniques (encouraging participation, dialogical approaches, providing opportunities and tailoring). There was evidence of constructs associated with individual empowerment, and building capacity, relationships and social networks. Evidence of constructs associated with community empowerment and mobilisation was limited. Existing service evaluation is influenced by organisational and translational factors and limits the ability to determine and document programme strengths.

Conclusion: Intervention fidelity, inclusion of content and techniques to build capacity, confidence and relationships represent programme strengths. There are missed

opportunities to recognise and report programme strengths, and to evaluate wider intervention effects. Adoption of a systematic, but flexible, approach to service evaluation, that provides prompts to facilitate operationalisation of community constructs and capture reflective practice, could add value to service providers and programme development.

3. Introduction

Current Public Health strategies prioritise tackling childhood obesity, ensuring children have the best start in life, community approaches, partnerships, and local solutions to empower individuals and communities (H.M. Government, 2016; Public Health England (PHE), 2014, 2015, 2015a; National Institute for Heath and Care Excellence (NICE), 2016). These strategies follow four decades of global directives that have driven a paradigm shift towards participatory, empowerment and community-centred health promotion (World Health Organisation (WHO), 2009; Bauman & Nutbeam, 2014).

Community-centred interventions are complex to plan, implement and evaluate; influenced by multiple factors, priorities and decisions (Mitchie et al., 2008; National Obesity Observatory (NOO), 2009). Inconsistencies in how associated constructs are conceptualised makes implementation and evaluation difficult (Wallerstein, 2006; Rawlett, 2014; Woodall, Raine, South & Warwick-Booth, 2010).

Evaluation plays a vital role within health promotion, and offers an important strategy to identify and inform good practice (NOO, 2009; Lobo, Petrich & Burns, 2014; Saunders, Evans & Joshi, 2005; WHO European Working Group on Health Promotion Evaluation, 1998; Smith & Ory, 2014). Despite interest in community-centred interventions and their evaluation, gaps between academic discourse, policy and practice remain (Bertotti, Jamal & Harden, 2012, Wallerstein, 2002; Adamson & Bromiley, 2013). Evaluation is often more driven by adequacy and efficiency than to inform good practice (Habicht, Victora & Vaughan, 1999; Lobo et al., 2014). More

detailed reporting of intervention evaluations is recommended to expand the evidence base (Mitchie et al., 2008; Rychetnik, Frommer, Hawe & Shell, 2002; PHE, 2015).

Despite growth in community-based nutrition interventions, and recognition of the role of parents in shaping children's dietary habits (Campbell & Hesketh, 2007); few studies have evaluated nutrition interventions delivered to this group (Hand et al., 2014; Taylor et al., 2013). Even fewer have considered empowerment within nutrition-based health promotion interventions, despite the propensity to lay claim to its facilitation (Brandstetter, Rütter, Curback & Loss, 2015).

Evaluations of nutrition based interventions typically apply bio-medical, quantitative methods (Contendo, Randell, & Basch, 2002; Brandstetter et al., 2015). Various frameworks provide criteria to facilitate process evaluation (NOO, 2009, 2012; Hand et al., 2015; Laverack & Labonte, 2000, Van Daele, Van Auden Hove, Herman, Van Den Bergh, & Van Den Broucke, 2012). Combining multiple methods is advocated as a valid appoach to evaluate community interventions (Bauman & Nutbeam, 2014; Braithwaite et al., 2013; Lipsey & Cordray, 2000; Wagemakers et al., 2010).

This study has, therefore, applied a mixed method approach to evaluate practice within a community-based healthy eating intervention targeting parents of children aged 1-4 years.

4. Methods

4.1 The Study Sample

The Toddler Nutrition Intervention is delivered to mothers of children aged 1 to 4 years as part of an Early Years Healthy Eating Programme provided by a Community Interest Company (CIC) (referred to as the 'service provider' to maintain anonymity). The intervention is delivered as five ninety minute weekly sessions, to up to six adults and their children, recruited from within the commissioning Children's Centre's geographical footprint.

'Intervention' refers to the five (previously six) week delivery, 'session' as the individual weekly delivery, and 'programme' as the rolling programme of interventions.

4.2 Research Design

Basing the study on a single community intervention was intended to elicit insights and rich understanding of the intervention: it's design, delivery, existing evaluation, and fidelity (Figure 1). The present study combined semi-structured interviews with the facilitator, and observations of delivery, with analysis of organisational documentation in a mixed methods approach, to identify evidence of what happens in practice and to develop a detailed description and evaluation of the intervention (Swift & Tischer, 2010; Braithwaite et al., 2013).

A systematic process of data collection and analysis was conducted, following a framework approach (Pope, Ziebland & Mays, 2000; Green et al., 2007), that included

a number of stages of data collection, cycles of coding, categorisation and interpretation, in an interpretive and iterative research process (Figure 1).

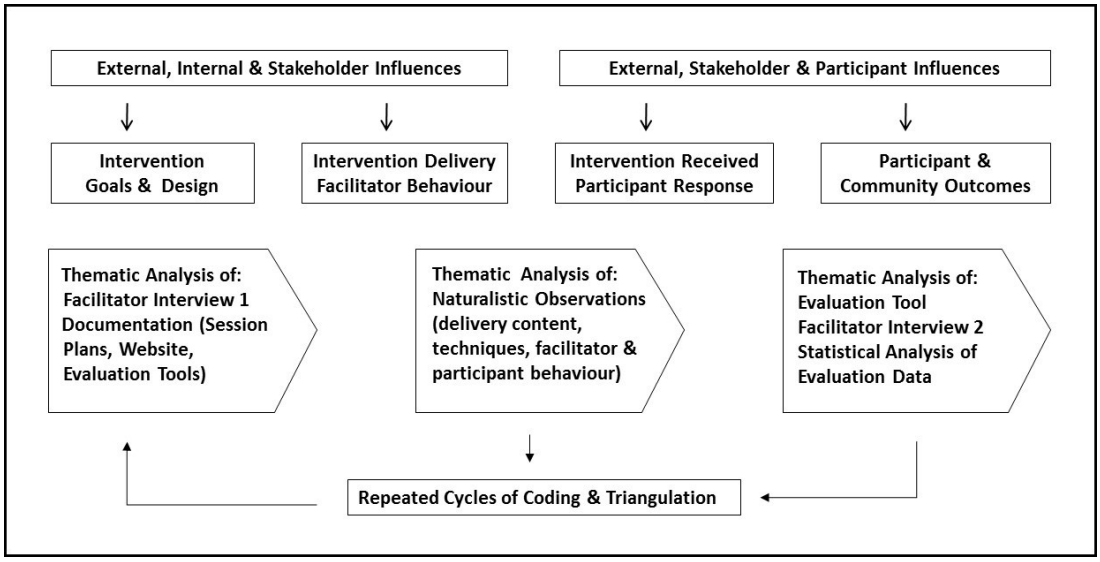

Figure 1. Data Collection and Analysis across the Intervention Process (adapted from Mitchie et al., 2008; NOO, 2009)

4.2.1 Ethical Approval

Ethical approval was obtained from University of Chester Faculty Research Ethics Committee (FREC) (Appendix 1).

4.3 Data Collection

4.3.1 Organisational Documentation

Organisational documentation included session plans and evaluation tools. Attendance and basic demographic information (adult and child ages, referred or self-referred) were gathered retrospectively from programme records covering a twenty-four month period (December 2014-October 2016). The service provider's website and Children's Centre self-evaluation reports, were accessed to enable a fuller description of the organisational structure, needs assessment and setting.

4.3.2 Existing User Generated Evaluation Data

Existing user evaluation consists of five point Likert-scale and open questions completed by intervention participants pre- and post-intervention; and an additional feedback questionnaire completed post-intervention (Appendix 2). Completed questionnaires for the twenty-four month period (December 2014-October 2016) were collected retrospectively.

4.3.3 Interviews

Two semi-structured face to face interviews were conducted with the intervention facilitator. The facilitator is responsible for planning, design, delivery and evaluation of the interventions, and is considered a key informant (Draper & Swift, 2011).

The first interview was conducted prior to the first session of an intervention to determine the facilitator's perceptions on the planning, goals, design, intended delivery and influencing factors. Interview questions were based on frameworks designed to facilitate detailed description of nutrition interventions (Saunders et al., 2005; Hand et al., 2015; Academy of Dietetics and Nutrition, n.d). A second theme of this first interview was to explore the facilitator's understanding of empowerment, participation and community approaches, and their operationalisation; questions were based on common constructs of empowerment and community (Shediac-Rizkallah & Bone, 1998; Ruderman, 2000; Wallerstein, 2002, 2006; Allsop & Heinsohm, 2005; Woodall et al., 2010; Liberato, Brimblecombe, Ritchie, Fergusin & Coveney, 2011; Laverack, 2016; Laverack & Wallerstein, 2001), (Appendix 3).

The first interview was sixty minutes in length. Interviews were audio recorded and transcribed verbatim to ensure a full and accurate record. Follow up questions were emailed to the facilitator and a second facilitator, previously responsible for the Toddler programme, to enable clarification.

The second interview, lasting thirty minutes, was conducted following the final session. Questions followed the same themes as the first interview, but were designed to enable the facilitator to reflect on the intervention delivered (Appendix 3). Both facilitators consented to participate in the study (Appendix 4); and were given the opportunity to check accuracy of transcription and findings.

4.3.4 Observations

Naturalistic observations were conducted during the first and last session. Substantive notes describing the setting, events, actions and conversations were taken throughout each ninety minutes session. An indicative list of themes was used as an *aide memoire* (Appendix 6). The sample for the observations consisted of the intervention facilitator and participants (four mothers in session 1, three mothers in session 5); all of whom had given consent to participate (Appendix 5). Participants were anonymised as participant 1-4. Observed sessions were audio recorded to facilitate accurate transcription and timing of observations.

The two time points were selected for pragmatic reasons, to obtain representative data related to delivery, content and techniques, and any observable changes in the roles or behaviours of facilitator and/or particpants pre-and post- intervention.

4.4 Data Analysis

Coding of interview and observation transcripts, session plans, and the existing evaluation tool followed themes related to delivery techniques, intervention content, and community and empowerment constructs. Interim analysis allowed coding based on themes identified from the underpinning literature and study objectives, as well as emerging themes (Appendix 7). Repeated cycles of coding, sub-categorisation and interpretation enabled greater coding consistency (Pope et al., 2000).

Participant demographic and attendance data was used to make inferences related to retention and reach (see definition Appendix 8). All participants were anonymised with a unique numerical indicator. Descriptive statistics are given as mean plus or minus standard deviation (mean ± SD); retention rates were calculated as a percentage. Evaluation data for the Weaning Intervention was used to verify participants attending both.

Pre- and post-intervention evaluation data provided ordinal data related to participant perceptions of confidence and behaviours. Non-parametric repeated measures were compared using a Wilcoxon Signed Rank Test. Statistical analysis was performed using SPSS version 23 for Windows (SPSS Inc, 2015). The criteria for statistical significance was set at $p < .05$.

4.4.1 Triangulation

Comparison and triangulation across data sources allowed a detailed description of the intervention to be developed, and identification of dominant, unifying themes and outliers (Fade & Swift, 2010). Triangulation enabled internal validity (Pilnick & Swift,

2010); and identification of consistency and gaps associated with different intervention stages to evaluate fidelity.

5. Results

5.1 Intervention Description

5.1.1 Setting and Organisational Structure

The intervention is delivered in, commissioned, and funded by, a Children's Centre, whose purpose is to address targets to reduce levels of childhood obesity and reduce social isolation. According to the facilitator, the area is:

> "one of the most deprived in the area, with high levels of unemployment, major social inequalities, high levels of obesity and young mothers" (Facilitator 1).

All Super Output Areas (SOAs) within the Children's Centre footprint are identified as in the top 30% Index of Multiple Deprivations (IMD). Within the 0-19 population 900 (32%) are under five years; the percentage of children aged 4-5 years that are obese increased from 9.6% in 2011/12 to 10.9% in 2012/13, compared to the regional average of 8.9% (Strategic Intelligence Team, 2015).

The Children's Centre identifies reducing inequalities in child development and school readiness; improving parenting aspirations, self-esteem and parenting skills; and improving child and family health and life chances as their priority targets. The Toddler Nutrition Intervention forms part of the strategy to promote maternal and healthy eating in early years in venues accessible to the wider community (Sure Start Children's Centre Summary, 2014; Strategic Intelligence Team, 2015). Facilitator 2 explained:

> "The idea was to have a healthy eating in pregnancy programme followed by the cookery skills and nutritional information for weaning, leading on to healthy eating for toddlers to provide a complete Early Years package of support."

To reduce barriers to access and increase reach delivery is in the Children's Centre, located in a residential area. Delivery consists of a taster session and five follow on sessions (previously 6 weeks). The intervention is professionally led and delivered by facilitators employed by the service provider, working in partnership with the Children's Centre and healthcare professionals including the Health Visiting team. The intervention is community-based (defined by setting, location and target group), rather than community-led (defined by collective action and resource mobilization (McLeroy, Norton, Keglar, Burdine & Sumaya, 2003)).

5.1.2 Intervention Goals, Design, and Influencing Factors

The main factors influencing intervention format and design are funding, policy, and the commissioning organisation's priority targets.

> "That comes down to the Children's Centre…funding is getting tighter and not knowing what is going to happen with the change to 0-19's contract we are going to have to relook at how we deliver the programmes […] that is a major influence – the funding allocation to the Children's Centre." (Facilitator 1)

The intervention has the main goal of delivering nutritional messages and skills, and to raise nutritional knowledge and awareness among participants.

> "by the time they get to reception you want the child to be at a healthy weight, and that the parents understand why that is important. So that the choices that they are making for themselves and their family are having a positive effect and understanding why that is the case." (Facilitator 1)

The service provider's webpage states:

> "Our Toddler Nutrition programme is aimed at mothers with children aged between 12 months and 4 years and is designed to empower parents and carers to confidently provide tasty and nutritious food for their young children and understand the nutritional requirements of under-5's." (reference on request)

The facilitator referred to guidelines and best-practice influencing design and delivery; including National Child Weight Measurement Programme, NICE Guidelines, working with the Early Years Foundation team, using motivational interviewing, and raising awareness of the first 1000 days as laying the foundations for good nutrition. Session plans are supported by reference to NHS Change4Life programme. Data gathered from the observations is consistent, with reference made during delivery to corresponding guidelines (Table 1).

5.1.3 Recruitment and Retention

The facilitator views attendance and retention as a success indicator, mentioning attendance in relation to evaluation four times, and strategies used to encourage retention three times during the first interview.

Documentation covered eight Toddler Nutrition Interventions over a 24 month period. Total number of registered participants was 33; after removal of spoils (records with

insufficient identification details, n=4) and duplicates (participants registered on several consecutive interventions, that were only kept in the intervention they attended most, n=7). Average age of participants was adults 31.7 ± 5.9 years and children 22.7 ± 9.9 months (range 8.5 to 48 months). Mean ± SD retention rate was 70% ± 25%.

The facilitator mentioned encouraging participants on the Weaning programme to join the Toddler programme, and evidence of this occurring, as an example of increasing reach and sustainability. From the attendance records, only two participants were identified as having attended both Interventions. The facilitator also commented on potential differences between referred and self-referred participants in relation to influences on retention and delivery. Intervention documentation identified six participants as referred, limiting further analysis.

In the observed intervention four participants (parents), out of six families recruited, attended; three of these attended all sessions. Facilitator 1 commented on the participants on this intervention being:

> "not the main core that we are looking for […] it is mums that are from the area but they are not from the most immediate footprint."

5.2 Intervention Delivery: Content, Methods and Techniques

Evidence from interviews, observations and session plans (Table 1), suggests consistency between the goals, intended delivery and actual delivery in relation to promoting nutritional messages, providing information and learning opportunities to

develop awareness, knowledge and cooking skills. Consistent reference to guidelines indicates their use in informing content and messages (Table1).

Content and delivery primarily focussed on providing opportunities for involvement in cooking activities. A range of delivery techniques that encourage participation were evident. Techniques included encouraging participation in activities and a dialogical approach, through questioning, positive reinforcement and support, and providing opportunities for discussion and sharing ideas. The facilitator also saw motivational interviewing as a technique to enable building positive relationships between practitioner and participants.

A strong theme within the interviews was building relationships and social networks; this was also evident from observations, but less evident on session plans (Table 1). Observation of session one showed that approximately 10% of the first session involved the practitioner providing information and 26% of the session provided time for participants to engage in informal conversation. Observations from the final session suggested more integrated conversation throughout the session, more equal sharing of ideas between practitioner and participant, and conversation more related to sharing experiences of dietary behaviours, preferences and accessing healthy alternatives.

Table 1. Comparison and Triangulation of Evidence Across the Intervention

Coding & Sub-categorisation	Facilitator Interviews	Organisational Documentation	Observations of Intervention Delivery
Promoting Nutritional Messages, Providing Information	Topics range from nutritional requirements, vitamins and minerals, breakfast sizes, portion sizes, different foods, batch cooking, oral health	Session plans identify providing information on nutrition requirements, oral health, food labels, sugars, portion sizes, healthy recipes	Importance of nutrition in early years, oral health, sugars, sources of protein, iron, five a day, vitamins, portion sizes, alternative ingredients
Content linked to Goals, Best Practice, Research or Guidelines	First 1000 days, NICE guidance, NHS Choices, BNF or BDA, National Child Weight Management Programme, Working with Early Years Foundation, Motivational interviewing	First 1000 days, Early Years Nutrition, 1450 message & MDF guidance, Caroline Walker Trust, Change4Life	First 1000 days, BNF portion size guide, Five a day,
Delivery Techniques Dialogical Tailoring[1]	Providing information Empowering Facilitating discussion & interaction Positive reinforcement Tailoring-matching content & ingredients to audience	Providing opportunities for discussion, posing questions, Promoting participation through activities & discussion	Providing information, support, positive reinforcement & encouragement, Opportunities for discussion, questioning & conversations, Role-modelling of behaviours, Tailoring
Empowerment [1] - Building Confidence	Confidence to: Meet with & engage with new people Be able to have the knowledge & skills Feel that they can do it To cook To make the right decisions & understand why		
Empowerment [1] Building Capacity - Knowledge & Raising Awareness	Providing resources, tools, knowledge & support	Providing information & raising awareness (nutrition requirements, oral health, food labels, sugars, portion sizes, healthy recipes)	Provided information to support Building knowledge & awareness of nutritional messages
Coping Mechanisms		Developing knowledge and coping strategies for dealing with a fussy eater	
Empowerment [1] Building Capacity - Skills Development	Opportunity to prepare & cook Cookery as tool to develop skills & engagement	Developing cooking skills	Skills development through participation in cooking, encouraging parent & child in cooking, tasting.
Behaviour Change	Facilitator commented on participant feedback (not giving as much juice, eating less sweetened & flavoured foods, trying to get more fruit & veg)	Moving away from shop bought snacks Introducing new foods & flavours	Opportunities to cook new recipes Participant discussion on accessing & trying alternative ingredients & foods

Empowerment [1] Opportunities for Choice, Transfer of Ownership, Participant Decision Making	"we have a session plan and ensure we cover things we are quite flexible […] we allow them to have the freedom of expression" "from the start we asked them what they wanted to pick up on" "that is kind of how they get involved in that they decide what they are going to make each week," "literally let them go and you support them …. the idea is that they lead on it themselves" "by being participant led in terms of recipes […] we leave them to it when they make the dishes, everyone has to have a go"	Opportunities for choice of recipes	Opportunities to share concerns, ideas & interests verbally & on pre-intervention evaluation Choice of recipes from list presented
Participation in Activities	Interactive cookery with parent & child Everyone has to have a go Participants were hands on, encouraged child to get involved, asked questions & gave feedback	Opportunities for participation in cooking activities	Active involvement of all participants in activities and in discussions, encouragement given to participate
Building Relationships, Social Networking, Sense of Community	Relationship building amongst the kids and a community among the parents "Relationship building. I think that is really important" "to come to a group once a week is like their support mechanism" "people I have met after said they still see others, or are friends on facebook […] they have built that social network […] kept that connection"		Opportunities provided for conversation, shared ideas and experiences
Partnerships	Volunteers from University Health Visitors or other support services Children's Centre Oral Health Practitioner		Facilitator refers to the Children's Centre at start of session, Oral Practitioner participates in one session; Volunteer present
Sustainability[1]/Broader Reach	Signposting to and encouraging participation in other community groups & events; Evidence of going from weaners to toddlers, accessing community centre & events more		Facilitator provided information & signposting to other community groups (weaning), Participants discussed participation in weaning intervention
[1] See Appendix 8 for definitions			

An emergent theme was responsive action and communication by the facilitator, coded as 'tailoring' (Appendix 8). In the words of the facilitator reflecting on the intervention delivered and observed:

> "we have emailed across information to them with regards to portion sizes and further reading if they wished, because they were of that calibre"
>
> "[..] what they wanted to look at was obviously embedded in and everything goes around that […] it was from week one really, you could tell when we asked them what they wanted to discover and to look at, and after week one you could see where their skill set was"
>
> "so that pre-intervention evaluation looked at what they wanted to look at and that then shaped how you delivered, and what we were delivering," (Facilitator 1)

Tailoring, or content matching, was evident both in terms of message customisation and appropriateness of materials and ingredients to the audience and local context.

Signposting to other community groups was evident from interviews and observations, this was viewed by the facilitator as a technique for promoting broader reach and sustainability. Table 1 suggests that some of the techniques and concepts observed in the delivery, and evidently valued by the facilitator (building confidence, building relationships, partnerships and sustainability), are not detailed within organisational documentation.

5.3 Evidence of Constructs Associated with Empowerment or Community-Centred Approaches

In relation to exploring empowerment as an approach, various comments were evident (Table 2), suggesting empowerment is perceived as integral in the intervention goals and design. Use of the term is consistent by facilitator and service provider, both frame it in terms of empowering participants to have confidence and skills necessary to choose and prepare healthy diets for themselves and their family.

Table 2: Evidence of Inclusion of Empowerment

Facilitator Interview Comments:	Service Provider Website Statement:
"I am facilitating that, providing the information […] empowering them at the same time" "Providing them with the skills and the tools to make a change that they know has positive effects or results." "In a simple way showing them how to make one of the recipes […] we are giving them the opportunity to prepare and cook a meal […] I think is empowering them to start creating a change, you are giving them the resources, the tools, the knowledge and the support, and the skills to do that" "facilitating, providing the information […] empowering them at the same time […] I think empowerment comes back to confidence"	"Our toddler nutrition programme […] is designed to empower parents and carers to confidently provide tasty and nutritious food for their young children"

There is evidence of constructs associated with empowerment and community-centred approaches, including capacity building, behaviour change, participation, and building confidence (Table 1). The facilitator suggested that delivery provided opportunities for transfer of ownership and participation in decision making (Table 1). Evidence from session plans and observational data of participant decision making was limited to choosing recipes from a suggested list. Evidence of other community empowerment constructs, such as leadership development, resource mobilisation and reflection, was limited.

5.4 Evaluation

5.4.1 Comments Relating to Evaluation from Interviews

Facilitators identified that a full evaluation was beyond budget, with raw data given to the Children's Centre for collation and reporting. Facilitators valued qualitative feedback from participants, indicating that the pre-evaluation form was used to inform modification of the intervention so that content is "logical and participant driven" (Facilitator 2). Attendance was viewed as a proxy measure of effectiveness (see section 5.1.3). Attendance was commented on anecdotally in relation to the Children's Centre needing two contacts per person to meet targets. The facilitator also commented on their own use of critical reflection, and when asked about this as part of the evaluation strategy, acknowledged this was not formalised.

5.4.2 The Evaluation Tool

The pre- and post-intervention evaluation tool consists of Likert questions, categorised as evaluating participant's perceptions of behaviour (Q.1,6,10), confidence

(Q.2,4,5,7,8,9) and knowledge (Q.3) in relation to healthy diet. Post-intervention feedback questions were categorised as related to raising awareness (Q.1,4), learning opportunities (Q.3), increased knowledge (Q.2), and behaviour change (Q.5); and to process evaluation or participant satisfaction (Q.6-11) (Appendix 2).

5.4.3 Statistical Analysis of Data from Evaluation Tools

Nineteen participants returned post-intervention feedback forms, of these nineteen had received at least 50%, and seven had received 100% of the intervention delivered. Responses suggest participants perceived increased knowledge or awareness of nutritional messages, and were satisfied with the intervention (Table 3).

Table 3. Most Frequent Participant Responses to Open Questions (n=19)

Type of comment	Number of comments
Less salt & sugar	19
Recipe ideas	15
Healthy snacks	12
Involving child	7
Portion sizes	6
More fruits and vegetables	5
Bottle to beaker	3
Balanced diet	1
Would like more 'healthy eating' sessions	15
Would recommend the intervention	14

Descriptive statistics for post-intervention Likert-scale questions are given in Table 4. In comparing data generated from the existing evaluation tool at the .05 significance level a significant difference was found for "I worry my child does not eat enough" (p= .012), pre-intervention mean±SD = 3.15±1.5 (n=27) and post-intervention mean±SD = 2.39±1.3 (n=18); and for "my child has milk in a beaker" (p= .026), pre-intervention mean ± SD = 2.79±1.7 (n=24) and post-intervention mean±SD = 4.18±1.2 (n=17). There

was no significant difference between all other pre- and post-intervention values (Table 4).

Table 4. Descriptive Statistics for Post-Intervention Data and Wilcoxon Signed Ranks Test to Compare Pre- and Post-Intervention Data

Question[1]	Code	Mean±SD	Asymp.Sig. (2-tailed)
1. I regularly cook or prepare meals for my toddler[1]	Behaviour change	3.9±0.74 (n=17)	P= .317
2. I feel confident in selecting healthy foods for my child[1]	Confidence	4.3±0.68 (n=17)	P= .655
3. I know what a healthy balanced diet for my toddler looks like[1]	Knowledge	4.4±0.51 (n=18)	P= .084
4. I feel confident in choosing healthy snacks for my child[1]	Confidence	4.3±0.82 (n=18)	P= .084
5. Meal times with my toddler can be stressful[1]	Confidence	3.2±0.98 (n=18)	P= .763
6. We regularly eat together as a family[1]	Behaviour change	4.0±0.90 (n=18)	P= .248
7. I worry about my child being a fussy eater[1]	Confidence	3.4±1.19 (n=18)	P= .201
8. I worry my child does not eat enough[1]	**Confidence**	**2.4±1.24 (n=18)**	**P= .012**[2.]
9. I worry my child eats too much[1]	Confidence	1.8±1.07 (n=17)	P= .194
10. My toddler has milk in a beaker[1]	**Behaviour change**	**4.2±1.18 (n=17)**	**P= .017**[2.]
1. Have these sessions provided you with more recipe ideas for cooking for you or with your toddler? [3]	Raising Awareness	5.0 (No Variance)	
2. Have these sessions increased your knowledge around sugar and oral health messages for your little one? [3]	Knowledge, Learning Opportunities	4.5±0.61 (n=19)	
3. Have these sessions taught you any new recipes? [3]	Learning Opportunities	4.9±0.09 (n=19)	
4. Have these sessions given you any new ideas about how to pack more fruit and vegetables into your little one's diet? [3]	Raising Awareness	4.5±0.7 (n=18)	

[1.] Likert scale (1=never, 3=sometimes, 5=always)

[2.] Significant at the P< .05 level

[3.] Likert scale (1=not helpful, 3=maybe, 5=very helpful)

6. Discussion

Intervention process (design, delivery and evaluation) was influenced by the economic, political and organisational context. These findings reaffirm the tendency towards adequacy and efficiency within service evaluation (Habicht et al., 1999), determined, in this case, by organisational factors (e.g. funding, resourcing and intervention duration) and translational factors (opportunities to convert knowledge into practice, differing priorities or understanding of success indicators), (Lobo et al., 2014). The limited use of evaluation data by the service provider mirrors the limited requirement for evaluation and evidence made by the funding agent, supporting Lobo et al.'s view (2014) that recurrent funding of short interventions and minimal evaluation requirements, limits the value placed on evaluation.

Existing evaluation data suggests positive perceptions of confidence, awareness and behaviours following the intervention (Tables 3 & 4). However, the limited evidence of statistically significant differences pre- and post-intervention, the small sample size, and differences in receipt of intervention, raises questions over the value of the existing evaluation to determine the effectiveness of the intervention.

Within the intervention, attendance and reach is valued as an indicator of success. This corresponds to the importance placed on these variables in both process and outcome evaluation (Nutbeam, 1998; Lipsey & Cordray, 2000; Saunders et al., 2005; Hand et al., 2014). The data suggests that recruited participants represent a relatively small proportion of the target population (n=33, in an identified population of 900 under 5's (Strategic Intelligence Team, 2015)). Observations related to the target group, and

small number of participants attending both Toddler and Weaning interventions, suggest the programme may not be maximising reach. More detailed data (referrals, recruitment, participant characteristics) is needed to enable a fuller analysis against identified success criteria, or comparison with similar interventions and target groups to explore possible influences on reach. This may be important for justification of future funding and programme sustainability, to determine impacts of differences in intervention receipt on outcomes, and to inform practice to increase reach.

Triangulation suggests programme fidelity across intervention goals, delivery and evaluation tools in their inclusion of techniques, content and measures related to nutritional messages, raising awareness, providing information, and learning opportunities to develop skills and knowledge (Table 1). There was consistent use of techniques that encourage participation (questioning, positive reinforcement, providing opportunities), a dialogical approach, and use of guidelines to inform design and delivery. Content matching, a form of tailoring was also evident (Hawkins, Kreuter, Resnicow, Fishbein & Dijkstra, 2008), indicating a balance between fidelity and adaptability. These criteria align with those incorporated in frameworks developed to evaluate nutrition interventions (Hand et al., 2015; Abram et al., 2015; NOO, 2012; Van Daele et al., 2012). These are considered programme strengths, informed by practitioner knowledge and competencies.

Both intervention documentation and facilitators defined empowerment in terms of building capacities and confidence, supporting the view that health promotion interventions typically focus on individual rather than community empowerment (Woodall et al., 2010, Woodall et al., 2012). The facilitator, seen as professional expert,

is fulfilling the suggested role in health promotion interventions as enabling and creating opportunities to increase awareness, capacities and confidence (Woodall et al., 2010; Laverack, 2006), and may be more accurately described as building a sense of control (Adamson, 2010; Adamson & Bromiley, 2003) or enabling (Jack, 1995).

Comparison of findings against empowerment frameworks (Laverack & Labonte, 2000; Laverack, 2016; Allsop & Heinsohn, 2005) suggest limited evidence of implementation of community empowerment constructs (leadership development, ownership, choices, sustainability); situating the intervention at the level of personal action and small group on the individual-community empowerment continuum.

Observational and interview data highlights an emphasis on building relationships, and social networks within delivery. This is acknowledged by the facilitator, but not within organisational documentation. The noted shift in style and content of dialogue across the two observations may represent an increasing sense of community and confidence among participants, and an initial step towards community building (Adamson, 2010). Partnerships with other community organisations, links with university volunteers, and encouragement of participants to access community events and resources was also evident. However, greater emphasis on ownership transfer, mobilisation, and leadership development or volunteering roles for participants, may be needed to move the intervention towards a more explicit empowering and community stance. McLeroy et al., (2003) suggest refocussing towards community building within health promotion interventions may offer the best potential for effectiveness; a view reflected in the strategic importance given to building resilient communities (PHE, 2014, 2015; NICE, 2016).

The facilitator commented on use of reflection, acknowledging that this was valued but not formalised; raising the question of missed opportunities to recognise, document and develop programme strengths. As a professionally led intervention, practitioner knowledge and expertise are key strengths, and call for tools to ameliorate documenting practice and reflections to facilitate management and sharing of knowledge and good practice. In line with recommendations for applying multiple methods (Bauman & Nutbeam, 2014; Nutbeam, 1998), flexible use of variables (Wagemakers et al., 2010) and appreciative inquiry methods (Lobo et al., 2014); the findings suggest that combining criteria from frameworks within a flexible approach to capture and document emerging reflections and evidence of techniques, may facilitate evaluation and operationalisation of wider intervention effects and further programme development.

6.1 Limitations and Weaknesses in the Study

This study was based on a context-specific, short-term community intervention, and sample size was small. Triangulation was applied to address internal validity, however transferability and generalisability is limited. The study did not seek to evaluate outcomes, but to explore process and practice. A full evaluation would require more comprehensive data collection and analysis of outcome measures.

The intervention, and hence data collection, were dependent on several stakeholders, and subject to change. This necessitated a flexible approach to data collection, retro-spective collection of some data sources (determined by availability), and limited the number of observations and inclusion of some methods. Participant focus groups and

videoing observations were excluded to avoid negative impacts on recruitment and retention, but could have offered more insight and validity.

The short duration of the study limited longer term measures, needed to evaluate community development and sustainability, and limited the extent of embedding of the researcher, needed for participatory action research which could have enabled fuller capture of opportunistic observations and emergent reflections, and a more iterative research process.

7. Conclusion

Combining multiple methods, and selective use of frameworks, to develop a detailed description of a community-based intervention and its operationalisation has identified content and techniques considered to be strengths within the intervention; and lends weight to the argument for adopting expansive multi-methodologies within intervention evaluations intended to inform good practice and programme development.

Intervention fidelity, tailoring, building individual capacity, confidence and social relationships were all evident across the intervention. These represent strengths, and confirm the practitioner's role as providing information, providing opportunities, and enabling. Findings also suggest a focus on individual empowerment, and use of proxy measures (e.g. confidence, attendance) within the intervention. Evidence of constructs associated with community empowerment and mobilisation was more limited, and may represent missed opportunities to recognise and develop wider intervention effects.

Adopting a simple and meaningful evaluation tool that enables systematic capture of what works well (successful techniques) and what could be modified, may be more efficient and efficacious in informing future practice, and of more value to the service provider than existing service evaluation. A tool that incorporates prompts for inclusion of constructs, for differentiating participant, facilitator and community actions, and to facilitate capture of emerging reflections is recommended.

8. References

Adamson, D. (2010). Community Empowerment. *International Journal of Sociology and Social Policy, 30(3/4):* 114 – 126, doi: 10.1108/01443331011033319

Adamson, D. & Bromiley, R. (2013). Community Empowerment: Learning from Practice in Community Regeneration. *International Journal of Public Sector Management, 26(3):* 190-202, doi: 10.1108/IJPSM-08-2011-0105

Academy of Dietetics and Nutrition (n.d.) *Guide for Effective Nutrition Interventions and Education (GENIE)*. Accessed from http://genie.webauthor.com/public/survey.cfm?form_id=96

Allsop, R. & Heinsohm, N. (2005). *Measuring Empowerment in Practice: Structuring Analysis and Framing Indicators.* World Bank Policy Research Working Paper 3510, February 2005.

Bauman, A. & Nutbeam, D. (2014). Planning and Evaluating Population Interventions to Reduce Non-Communicable Disease Risk – Reconciling Complexity and Scientific Rigour? *Public Health Research & Practice November, 25(1):* e2511402, doi: 10.17061/phrp2511402

Bertotti M., Jamal, F., & Harden, A. (2012). *A Review of Conceptualisations and Meaning of 'Community' within and across Research Traditions: A Meta-Narrative Approach.* London: AHRC, Accessed from http://www.ahrc.ac.uk/Funding-Opportunities/Research-funding/Connected-Communities/Scoping-studies-and-

reviews/Documents/A%20review%20of%20conceptualisations%20and%20meanings.pdf

Braithwaite, R.L., McKenzie, R.D., Pruitt, V., Holden, K.B., Aaron, K., & Hollimon, C. (2013). Community-Based Participatory Evaluation: The Healthy Start Approach. *Health Promotion Practice, 14(2):* 213–219 doi: 10.1177/1524839912443241

Brandstetter, S., Rüter, J., Curbach, J. & Loss, J. (2015). Review Article: A systematic Review on Empowerment for Healthy Nutrition in Health Promotion, *Public Health Nutrition, 18(17):* 3146–3154, doi: 10.1017/S1368980015000270

Campbell, K.J. & Hesketh, K.D (2007.) Strategies which aim to positively impact on weight, physical activity, diet and sedentary behaviours in children from zero to five years. A systematic review of the literature. *Obesity Reviews, 8:* 327-338, doi: 10.1111/j.1467-789X.2006.00305.x

Contendo, I.R., Randell, J.S., & Basch, C.E. (2002). Review and Analysis of Evaluation Measures Used in Nutrition Education Intervention Research. *Journal of Nutrition Education and Behavior, 34(1):* 2-25

Draper, A. & Swift, J.A. (2011). Qualitative research in nutrition and dietetics: data collection issues. *Journal of Human Nutrition and Dietetics, 24:* 3-12, doi:10.1111/j.1365-277X.2010.01117.x

Fade, S.A. & Swift, J.A. (2010). Qualitative research in nutrition and dietetics: data analysis issues. *Journal of Human Nutrition and Dietetics, 24: 106-114, doi:* doi:10.1111/j.1365-277X.2010.01118.x

Green, J., Willis, K., Hughes, E., Small, R. Welch, N. &Gibbs, L. (2007). Generating best evidence from qualitative research: the role of data analysis. *Australian and New Zealand Journal of Public Health,* 31 (6): 545-550, doi:10.1111/j.1753-6405.2007.00141.x

Habicht, J.P., Victora, C.G. & Vaughan, J.P. (1999). Evaluation Designs for Adequacy, Plausibility and Probability of Public Health Programme Performance and Impact. *International Journal of Epidemiology, 28:* 10-18

Hand, R.K., Abram, J.K., Brown, K., Ziegler, P.J., Parrott, J.S., & Steiber, A.L. (2015). Development and Validation of the Guide for Effective Nutrition Interventions and Education (GENIE): A Tool for Assessing the Quality of Proposed Nutrition Education Programs. *Journal of Nutrition Education and Behavior, 47(4):* 308-316, doi: http://dx.doi.org/10.1016/j.jneb.2015.03.003

Hand, R.K., Birnbaum, A.S., Carter, B.J., Medrow, L., Stern, E. & Brown, K. (2014). The RD Parent Empowerment Program Creates Measurable Change in the Behaviors of Low Income Families and Children: An Intervention Description and Evaluation. *Journal of the Academy of Nutrition and Dietetics, 114(12):* 1923-1931, doi: 10.1016/j.jand.2014.08.014

Hawkins, R.P., Kreuter, M., Resnicow, K., Fishbein, M., & Dijkstra, A. (2008). Understanding tailoring in communicating about health. *Health Education Research, 23(3):* 454-466, doi:10.1093/her/cyn004

H.M. Government (2016). *Childhood obesity: a plan for action.* August 2016. London: H.M. Government.

Jack, R. (1995). (Ed) *Empowerment in Community Care*. California: Chapman and Hall.

Laverack, G. (2006). Improving Health Outcomes through Community Empowerment: A Review of the Literature. *Journal Health Population Nutrition, 24(1):* 113-120

Laverack, G. (2016). *Public Health, Power, Empowerment and Professional Practices. 3rd Edition*. London: Palgrave.

Laverack, G. & Labonte, R. (2000). A Planning Framework for Community Empowerment Goals within Health Promotion. *Health Policy and Planning, 15(2):* 255-262

Laverack, G. & Wallerstein, N. (2001). Measuring community empowerment: a fresh look at organisational domains. *Health Promotion International, 16(2):* 179-185

Liberato, S.C., Brimblecombe, J., Ritchie, J., Ferguson, M. & Coveney, J. (2011). Measuring capacity building in communities: a review of the literature. *BMC Public Health, 11:* 850- 859

Lipsey, M.W. & Cordray, D.S. (2000). Evaluation Methods for Social Intervention. *Annual Review of Psychology, 51*: 345-375

Lobo, R., Petrich, M. & Burns, S.K. (2014). Supporting Health Promotion Practitioners to Undertake Evaluation for Programme Development. *BMC Public Health, 15:1315:* 1-8, doi: 10.1186/1471-2458-14-1315

McLeroy; K.R., Norton, B.L., Keglar; M.C. Burdine, J.N., & Sunaja, C.V. (2003). Editorial April 2003. *American Journal of Public Health, 93(4):* 529-533

Mitchie, S., Hardman, W., Fanshawe, T., Prevost, A.T., Taylor, L. & Kinmonth, A.L. (2008). Investigating theoretical explanations of behaviour change: The case study of ProActive. *Psychology & Health, 23(1):* 25-29 doi: 10.1080/08870440701670588

National Institute for Health and Care Excellence (NICE) (2016). *Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities 4 March 2016.* London: NICE Guidelines [NG44)

National Obesity Observatory (NOO) (2009). *Standard Evaluation Framework for Weight Management Interventions.* Oxford: The National Obesity Observatory.

National Obesity Observatory (NOO) (2012). *Standard Evaluation Framework for Dietary interventions.* Oxford: The National Obesity Observatory.

Nutbeam, D. (1998). Evaluating Health Promotion – Progress, Problems and Solutions. *Health Promotion International, 13(1):* 27-44

Pilnick, A. & Swift, J.A. (2010). Qualitative research in nutrition and dietetics: assessing quality. *Journal of Human Nutrition and Dietetics, 24*: 209-214, doi: 10.1111/j.1365-277X.2010.01120.x

Pope, C., Ziebland, S. & Mays, N. (2000). Qualitative research in health care: analysing qualitative data. *British Medical Journal,* 320: 114-116

Public Health England (PHE) (2014). *From Evidence in to Action: Opportunities to protect and improve the nation's health.* London: PHE Publications Gateway Number: 2014404

Public Health England (PHE) (2015). *A Guide to Community-Centred Approaches Full Report.* London: PHE Publications Gateway Number: 2014711

Public Health England (PHE) (2015a). *Guidelines: Childhood obesity: applying All Our Health.* Accessed 12 September 2016 from https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health

Public Health England (PHE) (2015b). *Evaluation of Weight Management, Physical Activity and Dietary Interventions: An Introductory Guide*. London: PHE Publications Gateway Number: 2015090

Rawlett, K.E. (2014). Journey from Self-Efficacy to Empowerment. *Health Care, 2(1*): 1-9, doi: 10.12966/hc.02.01.2014

Ruderman, M. (2000). *Resource Guide to Concepts and Methods for Community-Based and Collaborative Problem Solving.* Baltimore MD: Women's and Children's Health Policy Center Department of Population and Family Health Sciences Johns Hopkins University Bloomberg School of Public Health.

Rychetnik, L., Fromer, M. Hawe, P. & Shiell, A. (2002). Criteria for Evaluating Evidence on Public Health Interventions. *Journal of Epidemiology Community Health, 56:* 119–127

Saunders, R.P., Evans, M.H., & Joshi, P. (2005). Developing a Process Evaluation Plan for Assessing Health Promotion Program Implementation: A How to Guide. *Health Promotion Practice, 6(2)*: 137-147, doi: 10.1177/1524839904273387

Shediac-Rizkallah, M.C. & Bone, L.R. (1998). Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research, 13(1):* 87-108

Smith, M.L. & Ory, M.G. (2014). Measuring Success: Evaluation Article Types for the Public Health Education and Promotion Section of Frontiers in Public Health. *Frontiers in Public Health, 2:* 111-116, doi: 10.3389/ fpubh. 2014.00111

SPSS Inc. (2015). Released 2015. *SPSS Statistics for Windows, Version 23.0*. Chicago: SPSS Inc.

Strategic Intelligence Team (2015). *Locality Dashboard Final V2-RS2015-06-01*

Sure Start Children's Centre Summary Self-Evaluation Form (SEF) (2014). *Ellesmere Port Group 2 – Portside Parklands Woodlands Children Centre Version 2 April 2014*, (URN 80146)

Swift, J.A. & Tischer, V. (2010). Qualitative Research in Nutrition and Dietetics: Getting Started. *Journal of Human Nutrition and Dietetics, 23*: 559-566, doi: 10.1111/j.1365-277X.2010.01116.x

Taylor, N.J., Sahota, P., Sargent, J., Barber, S., Loach, J, Louch, G & Wright, J. (2013). Using intervention mapping to develop a culturally appropriate intervention to

prevent childhood obesity: the HAPPY (Healthy and Active Parenting Programme for Early Years) study. *International Journal of Behavioral Nutrition and Physical Activity, 10*:142-157

Van Daele, T., Van Auden Hove, C., Herman, D., Van Den Bergh, O. & Van Den Broucke, S. (2012). Empowerment implementation: enhancing fidelity and adaptation in a psycho-educational intervention. *Health Promotion International, 29(2):* 212-222. doi: 10.1093/heapro/das070

Wagemakers, A., Vaandrager, L. Koelen, M.A., Saan, H. & Leeuwis, C. (2010). Community Health Promotion: A Framework to Facilitate and Evaluate Supportive Social Environments for Health. *Evaluation and Program Planning, 33:* 428-435, doi: 10.1016/j.evalprogplan.2009.12.008

Wallerstein, N. (2002). Empowerment to Reduce Health Disparities, *Scandinavian Journal Public Health, 30:* 72-77

Wallerstein, N. (2006). *What is the Evidence on Effectiveness of Empowerment to Improve Health?* Copenhagen: WHO Regional Office for Europe. Health Evidence Network Report. Accessed 9 June 2016 from http://www.euro.who.int/Document/E88086.pdf

Woodall, J., Raine, G., South, J. & Warwick-Booth, L. (2010*). Empowerment and Health & Well-Being Evidence Review.* Centre for Health Promotion Research, Leeds Metropolitan University.

Woodall, J.R., Warwick-Booth, L. & Cross, R. (2012). Has Empowerment Lost its Power? *Health Education Research, 27(4):* 742-745, doi:10.1093/her/cys064

World Health Organisation (WHO) European Working Group on Health Promotion Evaluation (1998). *Health Promotion Evaluation: Recommendations to Policy-Makers Report of the WHO European Working Group on Health Promotion Evaluation* EUR/ICP/IVST 05 01 03

World Health Organization (WHO) (2009). *Milestones in Health Promotion: Statements from Global Conferences.* Geneva: WHO

9. Appendices

Appendix 1. FREC Ethics Approval

Faculty of Medicine, Dentistry and Clinical Sciences
Research Ethics Committee

frec@chester.ac.uk

23/06/2016

Judith Flynn
Rue des Combette
Le Paquier 1661
Switzerland

Dear Judith

Study title:	***Evaluating a community based health promotion intervention as a vehicle for individual and community empowerment.***
FREC reference:	***1199/16/JK/CSN***
Version number:	***1***

Thank you for sending your application to the Faculty of Medicine, Dentistry and Clinical Sciences Research Ethics Committee for review.

I am pleased to confirm ethical approval for the above research, provided that you comply with the conditions set out in the attached document, and adhere to the processes described in your application form and supporting documentation.

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application Form	1	May 2016
Appendix 1 – List of References	1	May 2016
Appendix 2 – Summary CV for Lead Researcher	1	May 2016
Appendix 3 – Risk Assessment	1	May 2016
Appendix 4a&b – Participant Information Sheet [PIS]	1	May 2016
Appendix 5 – Letter(s) of invitation to participants	1	May 2016
Appendix 6 - Consent Form	1	May 2016
Appendix 7 – Written permission(s) from relevant personnel (eg. to use faculties)	1	May 2016
Appendix 8 – Interview schedule(s) or topic guide(s)	1	May 2016

Appendix 9 – Indicative list of themes for observations and data coding	1	May 2016
Appendix 10 – Recording sheet for observations	1	May 2016
Appendix 11 – Existing Health Box Evaluation Tool	1	May 2016
Response to FREC request for further information or clarification	1	

Please note that this approval is given in accordance with the requirements of English law only. For research taking place wholly or partly within other jurisdictions (including Wales, Scotland and Northern Ireland), you should seek further advice from the Committee Chair / Secretary or the Research and Knowledge Transfer Office and may need additional approval from the appropriate agencies in the country (or countries) in which the research will take place.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Professor Ben Green
Chair, Faculty Research Ethics Committee

Enclosures: Standard conditions of approval.

Cc. Supervisor/FREC Representative

Appendix 2. Existing Evaluation Tool with Coding

Question	Code
Pre- and Post- Intervention Evaluation Likert scale (1=never, 3=sometimes, 5=always)	
1. I regularly cook or prepare meals for my toddler	Behaviour change
2. I feel confident in selecting healthy foods for my child	Confidence
3. I know what a healthy balanced diet for my toddler looks like	Knowledge
4. I feel confident in choosing healthy snacks for my child	Confidence
5. Meal times with my toddler can be stressful	Confidence
6. We regularly eat together as a family	Behaviour Change
7. I worry about my child being a fussy eater	Confidence
8. I worry my child does not eat enough	Confidence
9. I worry my child eats too much	Confidence
10. My toddler has milk in a beaker	Behaviour Change
11. The topic I want to most learn is/ The most useful topic I learnt was	Open / Learning Opportunity
Post Intervention Feedback Evaluation Likert scale (1=not helpful, 3=maybe, 5=very helpful)	
1. Have these sessions provided you with more recipe ideas for cooking for you or with your toddler?	Raising Awareness
2. Have these sessions increased your knowledge around sugar and oral health messages for your little one?	Knowledge, (Learning Opportunities)
3. Have these sessions taught you any new recipes?	Learning Opportunities
4. Have these sessions given you any new ideas about how to pack more fruit and vegetables into your little one's diet?	Raising Awareness
5. Have you changed anything about your child's diet as a result of attending these sessions? Yes/No 5b What?	Behaviour Change
6. How have you benefitted from attending these sessions or what have you learnt	Open
7. Has there been any sections of the programme you have particularly enjoyed?	Process Evaluation - Satisfaction
8. Has there been any sessions you have not enjoyed?	Process Evaluation - Satisfaction
9. Would you like us to deliver more healthy eating or lifestyle sessions in the future? Yes/No	Process Evaluation - Satisfaction
10. Would you recommend this course to a friend?	Process Evaluation - Satisfaction
11. Can you suggest any improvements to our sessions?	Process Evaluation - Satisfaction

Appendix 3. Semi-Structured Facilitator Interview Questions

To describe the intervention (content, activities and parameters)
Questions at the start of the intervention (interview 1): What are the aims, goals and objectives of the programme? (measurable, short term, long term) Who is your target group, and why? How are the participants recruited onto the programme? (procedures for attracting or approaching?) Any links to best practice or needs assessment? What is the setting for the programme delivery? What factors influence this? How do you address retention issues? Do you do anything to promote those attending weaning group to go on to do toddler group? **Questions at the end of the intervention (interview 2):** What proportion of the intended target group participated? Was there any drop out (and was this followed up, how?)
To evaluate factors influencing the protocol, design, delivery and evaluation of the programme
Questions at the start of the intervention (interview 1): What do you consider to be the main factors that influence the design of the programme? Are there any organisational or situational factors that affect the design or implementation of the programme? (community, social/political) Are there any key stakeholders/stakeholder requirements that impact your decision making when planning and designing the programme…and the evaluation you currently use? What other partnerships are involved in the programme?
To analyse consistency and gaps within the process of design, delivery, receipt and evaluation of the intervention
Questions at the start of the intervention (interview 1): How do you integrate theory or best practice within the programme? Can you give examples? How do you address external influences on food related behaviours? How do you ensure programme content links to the goals; and to best practice? How do you ensure content and materials meet the need of the audience? (Can you give examples/indication of techniques you use to promote learning, meet needs of different learning styles, to motivate participants and / or to promote nutritional or lifestyle behavioural change? To what extent and how are participants involved in the planning and delivery (decision making)? **Questions at the end of the intervention (interview 2):** Invitation to reflect on the delivery as an open question Reflecting on this delivery: To what extent do you feel participants were satisfied with the programme – what is this view based on? To what extent were participants actively engage in materials and activities? What kinds of decisions were participants making?

To what extent did participants engage in any recommendations for follow up activities?...examples? How did participants react to specific aspects of the intervention…any examples? To what extent do you feel the programme delivered was provided as planned or in line with the goals? How do you integrate theory or best practice within the programme? Can you give examples? To what extent do you feel external influences on food related behaviours were addressed? How did you ensure content and materials met the need of the audience? (Can you give examples/indication of techniques you use to promote learning, meet needs of different learning styles, to motivate participants and / or to promote nutritional or lifestyle behavioural change? Were there any specific topics or issues you picked up on from the initial pre-intervention evaluation that you then built in or adapted the programme to address? Were there any issues or topics that emerged during the 5 weeks that you picked up on during the delivery and caused you to adapt the programme?
To identify if, what and how constructs and techniques associated with empowering individuals and communities are applied across the programme
Questions at the start of the intervention (interview 1): How would you define empowerment, and how do you build this into the programme design and delivery? To what extent & how are you incorporating any of the following into the design and delivery? Building Confidence Facilitating greater sense of control Building Capacity (knowledge, awareness, skills development and learning opportunities) Behaviour change Participation Greater sense of community Is there anything you do or that you feel occurs as a result of the programme that relates to the participants after the end of the programme? What potential is there for the programme having a broader reach or for continued action after the programme finishes?
To explore if existing evaluation tool is an effective measure of the intervention
Questions at the start of the intervention (interview 1): What does your existing evaluation tool measure? What factors influence the design of this? **Questions at the end of the intervention (interview 2):** Questions to clarify earlier interviews and understanding of the intervention documentation: You said the evaluation data is given in raw form to the children's centre, do you know what they are doing with it? Is there any plan for analysis of it? You mentioned lack of funding/resource in terms of your ability to do more with evaluation, do you know what proportion of the time or budget al.located within the programme is for evaluation? – is this factored in at all?

Appendix 4. Sample Facilitator Consent Form

Title of Project: Evaluating a Community Based Health Intervention as a vehicle for Individual and Community Empowerment

Name of Researcher: Judith Fynn

Consent Form for Intervention Facilitator

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected. ☐
3. I give permission for sessions that are observed by the researcher to be audio recorded to assist with later analysis. ☐
4. I give permission for interviews that I participate in to be audio recorded. ☐
5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

1 for participant; 1 for researcher

Appendix 5. Sample Participant Consent Form

Title of Project: Evaluating a Community Based Health Intervention as a vehicle for Individual and Community Empowerment

Name of Researcher: Judith Fynn

Consent Form for Intervention Participants

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected. ☐
3. I give permission for sessions that are observed by the researcher to be audio recorded to assist with later analysis. ☐
4. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Researcher	Date	Signature

1 for participant; 1 for researcher

Appendix 6. Aide Memoir for Observations

Evidence of actions/content in the programme of:

Individual Empowerment:

- Building Confidence (self-esteem, self-efficacy, sense of personal control)
- Facilitating greater sense of control (Facilitating reflection and evaluation skills)
- Building Capacity (increased knowledge & awareness, coping mechanisms, skills development and learning opportunities)
- Behaviour change (commitment and evidence to action)
- Participation, (Evidence of promoting equality in relationship of professional and participants, participatory decision making in the process of the programme planning & delivery, shared goals and vision, active involvement, ownership)

Community Empowerment / Sustainability / System Challenge:

- Community capacity
- Building Partnerships
- Collective action (increased desire to advocate, initiate or lead), mobilization
- Greater sense of community, increasing social networks/support,
- Evidence of the programmes co-ordination with other community forums and organisations, wider policy strategies

Appendix 7. Final Codes for Interviews, Observations and Documentation

Evidence of actions, techniques and content within the intervention:

Main Code	Sub-Categories
Description (design)	Target Group Goals (promotes healthy eating or behaviours, Promotes nutrition messages, healthy weight, behaviour change) Organisation (Partnerships, Influencing Factors, Best practice, Funding, Policy) Setting Attendance Recruitment, Retention
Delivery (techniques & content)	Promote learning, Motivation, Promote nutritional messages &/or healthy behaviours Content (Linked to Goals, Best Practice, Research, Guidelines) Actions by Experts, Volunteers, Participants, Lay-leaders (Role modelling, Responsive action/Tailoring, Support, Positive reinforcement) Materials (relevance, appropriateness) Opportunities for choice Transfer of ownership
Delivery - IE - Building Confidence	Self-esteem, Efficacy, or Sense of control, Confidence
Delivery - IE - Building Capacity, Building Competencies	Knowledge, Raising Awareness, Coping mechanisms, Skills development, Learning opportunities, Providing information, Leadership development, Resource mobilization, Reflection
Delivery - CE / IE - Behaviour change (commitment & evidence to action)	Promoting nutritional change, healthy behaviours
Delivery - CE / IE - Participation	Attendance Opportunities for Choice Decision making (Panning, Delivery, Evaluation) Active involvement (Discussion, Activity) Ownership
Delivery - CE - Social / Community	Social Networking, Sense of Community, Shared values, Dialogical, Building relationships (practitioner & participant, between participants), Partnerships – coordination with other community groups Sustainability/Broader Reach
Evaluation	Process monitoring, Reflection, Outcome measures, Attendance, Analysis Planning

CE = Community Empowerment, IE = Individual Empowerment

Appendix 8. List of Definitions

Community - A group of people that share common interests, goals and/or identities, that may be further defined by location or common characteristics and the social interactions that link members (PHE, 2015; NICE, 2015).

Community-centred - Relates to a wide variety of community approaches including community-based and community-led (PHE, 2015).

Empowerment - Enabling "individuals and communities to assume more power over the personal, socioeconomic and environmental factors that affect their health" (WHO European Working Group on Health Promotion Evaluation, 1998 annex 2 p.8).

Evaluation - "the systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness." (WHO European Working Group, 1998, p.3).

Fidelity - Extent to which intervention was implemented as planned (Saunders, Evans & Joshi, 2005).

Health Assets - The collective resources (or capital) which individuals and communities have that may be used to promote improvements in health and reduce health inequalities (Glasgow Centre for Population Studies, 2011).

Intervention - a set of actions with an objective to bring about identifiable outcomes, such as a locally situated health intervention or multi-component programme (Rychetnik et al., 2002).

Process Evaluation – Evaluation of what is happening within an intervention, often intended to inform its development. (PHE, 2015b)

Reach - Proportion of the target audience that participates in the intervention, linked to recruitment, attendance and participation rates (Saunders et al., 2005).

Sustainable - The capability to continue or maintain the intervention, behaviours, or outcomes achieved through the initial intervention beyond the intervention delivery/receipt (Shediac -Rizkallah & Bone, 1998).

Tailoring - A process of adapting the delivery or message to increase relevancy to the audience (Hand et al., 2014).